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 Telephone: 780-427-0731 Fax: 780-422-0968.

This request needs to be uploaded to the Alberta Blue Cross Online Health Portal for funding to be considered.

Please indicate if the form is for Clients (age 18 or older) who request ventilator support for respiratory insufficiency caused by

- Rapidly progressive neuromuscular conditions, or
- Stable or slowly progressive neuromuscular, musculoskeletal or spinal cord conditions

Urgent for the following reason(s). **Please phone Alberta Blue Cross AADL Provider Line 587-756-8629**

- Client requires BPAP for hospital discharge or to prevent hospital (re)admission.
- Client starts on BPAP and oxygen at the same time.
- Other (specify)

1. Client's Name (Last, First) _____

PHN _____ Date of Birth (yyyy-mm-dd) _____ - _____ - _____

Address _____

City _____ Postal Code _____ Telephone Number _____

2. Respiratory Assessor (Last, First Name)

Designation RRT Other _____ Facility Name _____

Phone _____ Fax _____

3. If Client is in the hospital, provide hospital name and unit _____

Tentative discharge date (yyyy-mm-dd) _____

4. Current Diagnosis

If Client has a rapidly progressive neuromuscular condition, go to Step 5. For other conditions, go to Step 6.

5. Clients who request BPAP for respiratory insufficiency caused by rapidly progressive neuromuscular conditions must meet one of the following

- | | |
|---|--|
| a) ABG at rest with PaCO ₂ ≥ 45 (attach copy) <input type="checkbox"/> Yes <input type="checkbox"/> No | b) PFT with FVC ≤ 50% predicted (attach copy) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Sniff nasal pressure < 40 cmH ₂ O <input type="checkbox"/> Yes <input type="checkbox"/> No | d) PI max < 40 cmH ₂ O <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e) Persistent Orthopnea <input type="checkbox"/> Yes <input type="checkbox"/> No | f) PSG with an increase of TcCO ₂ ≥ 10 mmHg (attach histogram, summary and interpretation) <input type="checkbox"/> Yes <input type="checkbox"/> No |

Client's Name (Last, First)

6. Clients who request BPAP for respiratory insufficiency caused by stable or slowly progressive neuromuscular, musculoskeletal or spinal cord conditions must meet one of the following while in a stable state:

- a) ABG at rest with PaCO₂ \geq 45 (attach copy) Yes No b) Orthopnea with a drop in VC of 20% in supine position versus sitting upright (attach copy) Yes No
- c) PSG with an increase of TcCO₂ \geq 10 mmHg Yes No
(attach histogram, summary and interpretation)

7. Prescribed BPAP Settings:

Mode S S/T PC AVAPS iVAPS No Substitutions

IPAP min ____ IPAP max ____ EPAP ____ Rise ____ Rate ____ Ti ____ Vt ____ Ramp ____ O₂ ____

Height (if prescribing iVAPS): _____ Other: _____

8. Preferred BPAP Specialty Supplier _____

9. Does client require oxygen with the BPAP? Yes No

If yes, the oxygen Specialty Supplier will be the same as the BPAP Specialty Supplier wherever possible.

10. Prescribing Physician Name (Last, First) _____

Phone _____ Fax _____

Date (yyyy-mm-dd) _____ Signature _____

This form must be signed by a certified pulmonologist.

11. Comments

How to Complete the Prescription and Request Form for BPAP Funding for Adults with Neuromuscular, Musculoskeletal or Spinal Cord Conditions

This form is for Clients (age 18 or older) who request ventilatory support for respiratory insufficiency caused by rapidly progressive neuromuscular conditions or stable/slowly progressive neuromuscular, musculoskeletal or spinal cord conditions.

1. Provide Client's name, personal health number and date of birth as they appear on their Alberta Personal Health Card. Provide Client's address, including postal code and the contact number.
2. Provide the name, designation, facility and the contact information of the Respiratory Assessor who completes the request form. The Respiratory Assessor must ensure the information provided to be true and correct.
3. If Client is in the hospital, provide the name of the hospital, the station or unit number and Client's tentative discharge date.
4. Provide current diagnosis:

Client with rapidly progressive neuromuscular conditions must have one of the following diagnoses:
 - a) Amyotrophic Lateral Sclerosis
 - b) Primary Lateral Sclerosis
 - c) Progressive Muscular Atrophy
 - d) Pseudobulbar Palsy
 - e) Progressive Bulbar Palsy
Client with stable/slowly progressive neuromuscular, musculoskeletal or spinal cord conditions must have one of the following:
 - a) Stable or slowly progressive neuromuscular disorders, e.g. Post Polio Syndrome.
 - b) Primary disorders of respiratory muscles, e.g. Muscular Dystrophy.
 - c) Chest wall deformities leading to restrictive disorders of the lung, e.g., Kyphoscoliosis.
 - d) Traumatic spinal injuries, e.g. Quadriplegia.
5. Client with rapidly progressive neuromuscular conditions must meet one of the following requirements:
 - a) ABG obtained at rest with PaCO₂ greater than or equal to 45 (attach copy).
 - b) Pulmonary function test showing Forced Vital Capacity (FVC) less than or equal to 50% predicted (attach copy with interpretation).
 - c) Sniff nasal pressure less than 40 cmH₂O.
 - d) PI max less than 40 cmH₂O.
 - e) Persistent Orthopnea.
 - f) PSG showing nocturnal hypoventilation with an increase of TcCO₂ at least 10 mmHg (attach histogram, summary and interpretation).
6. Client with stable or slowly progressive neuromuscular, musculoskeletal or spinal cord conditions must meet one of the following requirements obtained while in a stable state (recovered to baseline from any acute illness):
 - a) ABG obtained at rest with PaCO₂ greater than or equal to 45 (attach copy).
 - b) Orthopnea with a drop in Vital Capacity (VC) of at least 20% in supine versus sitting upright (attach copy).
 - c) PSG showing nocturnal hypoventilation with an increase of TcCO₂ at least 10 mmHg (attach histogram, summary and interpretation).
7. Provide the data of the BPAP mode and settings on this request.
8. Provide preferred BPAP Specialty Supplier. It shall be based on Client's needs and Client's current relationship with the Specialty Supplier.
9. If oxygen is approved with the BPAP, the oxygen Specialty Supplier will be the same as the BPAP Specialty Supplier whenever possible.
10. Provide the name, phone number, fax number and signature of the prescribing physician. It must be signed by a certified pulmonologist. No separate BPAP prescription is required.
11. Provide comments if any.