



RX ORDER CHECK LIST/ FAX COVER SHEET

FAX: 888-793-2319

Table with 4 columns: To, Facility Name, Fax, Sender Name, Date, Sender phone, Re: Prescription for AffloVest, Sender Email, # of Pages

PLEASE INCLUDE THE FOLLOWING ITEMS (if applicable):

- Physician Signed and Dated Prescription with physician NPI
Patient Demographics/Face Sheet
Copy of Patient's Insurance Card(s) (front and back)
Medical Records for the past 6 months, including any referral letters and hospital discharge summaries

PLEASE NOTE: The following items must be documented in the patient's medical record to support the prescription for vest therapy:

- Face-to-face encounter (Must be on or during the 6 months prior to the date of the vest therapy prescription)
Other airway clearance treatment option that was tried and why it failed OR an airway clearance treatment option that was considered and why it was not an appropriate option.

FOR BRONCHIECTASIS PATIENTS:

- Chest CT scan confirming diagnosis (Include CT scan report)
Documentation in medical record of:
A) Daily productive cough for at least 6 continuous months (Example: "Patient reports daily productive cough in excess of six months": OR
B) Pulmonary exacerbation requiring antibiotic therapy at least 3 times within the last year

Note: The diagnosis of bronchiectasis must be based on a CT scan. If the diagnosis of bronchiectasis does not appear in the radiology report, a pulmonologist's diagnosis of bronchiectasis may be sufficient, provided it is specifically based on and references the scan provided and those findings are included in a provided progress note.

Example: "Reviewed CT scan done on XX/XX/XX and find evidence of bronchiectasis present".

QUESTIONS? Call AffloVest at 888-711-1145

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