Prescription for Luna G3 Devices and Supplies

REACTHEALTH

Patient Name: _____
Address: _____
_____
DOB: _____
Phone Number: _____
Diagnosis: ☐ OSA ICD-10 G47.33
☐ Other: _____

Prescription Date: _____
Insurance Name: _____
Insurance Number: _____
Date seen prior to sleep test: _____
Diagnosis test date: _____
Length of need: ☐ 99 Months ☐ Other: _____

APAP Therapy E0601 + E0562 + A9279

Luna G3 APAP *with Heated Humidifier*

☐ Auto CPAP mode
Min APAP: _____ cm H20 (4-20 cm H2O)
Max APAP: _____ cm H20 (4-20 cm H2O)
Ramp Time: ☑ Auto ☑ Off ☐ ____ (60 min max)
RESlex™: ☐ OFF ☐ 1 ☐ 2 ☐ 3 ☐ Patient

CPAP Therapy E0601 + E0562 + A9279

Luna G3 APAP *with Heated Humidifier*

☐ CPAP mode
Treat P: _____ cm H20 (4-20 cm H2O)
Ramp Time: ☐ Auto ☐ Off ☐ 111 (60 min max)
Initial P: _____ (Ramp Pressure)
RESlex™: ☐ OFF ☐ 1 ☐ 2 ☐ 3 ☐ Patient

Bilevel Therapy E0470 + E0562 + A9279

Luna G3 Bilevel 25A *with Heated Humidifier*

☐ S mode
EPAP: _____ cm H20 (4-25 cm H2O)
IPAP: _____ cm H20 (4-25 cm H2O)
Ramp Time: ☐ Auto ☐ Off ☐ ____ (60 min max)
Initial P: _____ (Ramp Pressure)
RESlex™: ☐ OFF ☐ 1 ☐ 2 ☐ 3 ☐ Patient

☐ Auto S mode (Fixed Pressure Support)
Min EPAP: _____ cm H20 (4-25 cm H2O)
Min IPAP: _____ cm H20 (8-25 cm H2O)
(Min IPAP-Min EPAP=Fixed PS)
Max IPAP: _____ cm H20 (4-25 cm H2O)
Ramp Time: ☐ Auto ☐ Off ☐ ____ (60 min max)
Initial P: _____ (Ramp Pressure)
RESlex™: ☐ OFF ☐ 1 ☐ 2 ☐ 3 ☐ Patient

Bilevel Therapy w/ Back Up Rate (RAD) E0471 + E0562 + A9279

Luna G3 Bilevel 30 VT *with Heated Humidifier*

☐ S/T mode - Target VT OFF
EPAP: _____ cm H20 (4-30 cm H2O)
IPAP: _____ cm H20 (4-30 cm H2O)
RR: _____ BPM (3-30 BPM)
Ti: _____ sec (0.3-1 sec)

☐ S/T mode - Target VT ON
(Variable Pressure Support)
Target VT: _____ ml (150-1500 ml)
EPAP: _____ cm H20 (4-30 cm H2O)
Min IPAP: _____ cm H20 (4-30 cm H2O)
Max IPAP: _____ cm H20 (4-30 cm H2O)
RR: _____ BPM (3-30 BPM)
Ti: _____ sec (0.3-1 sec)

☐ Remote Monitoring: Link Physician to patient in React Health Connect

Attach

1) Copy of sleep test. 2) Copy of medical record from initial face-to-face prior to sleep test.
Medicare and commercial payors will not authorize service without supporting documentation.

Supplies

☐ Siesta Full Face Mask *A7031*
☐ Siesta Nasal Face Mask *A7034*
☐ Rio II Nasal Pillows *A7034*
☐ Water Chamber *A7046* ☐ VCom
☐ Heated Tubing *A4604*
☐ Non Heated Standard Tubing *A7037*
☐ Non Disposable Filters *A7039*
☐ Disposable Filters *A7038*

Practitioner Name: _____ Date: _____

Signature: _____ NPI: _____

Statement of medical necessity: *The above patient has undergone diagnostic evaluation. This evaluation has confirmed a positive diagnosis of sleep apnea. Positive airway pressure therapy is medically necessary and provides effective treatment of this disorder.*