



Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219	ColoradoPAR Program Medical Review Department	Phone: 1-720-689-6340 Fax: 1-800-922-3508
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**QUESTIONNAIRE #6
PULSE OXIMETER - ADULT 21+**

Member Name		Health First Colorado ID #	
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Length of Need		End Date		Height		Weight	
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The information requested below is required to determine medical necessity. Complete this form and attach to the completed Prior Authorization Request (PAR).

1. What is the complete diagnosis with complicating factors? Note: If COPD is the primary diagnosis, additional respiratory diagnosis is required.									
2. Is the member on oxygen? If yes, how many liters per minute (lpm)?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ lpm <input type="checkbox"/> Continuous <input type="checkbox"/> Nocturnal Only <input type="checkbox"/> Exercise Only								
3. Is the pulse oximeter request for? If spot check, provide the member's last three dates and readings.	<input type="checkbox"/> Spot Check Monitoring <input type="checkbox"/> Continuous Monitoring <table border="1" style="width: 100%;"> <tr> <td style="width: 15%;">Date</td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> <tr> <td>Reading</td> <td></td> <td></td> <td></td> </tr> </table>	Date				Reading			
Date									
Reading									
4. What are the underlying conditions/circumstances that indicates the need for a continuous pulse oximeter? Note: Only one needed to qualify.	<input type="checkbox"/> Monitor desaturation with/without oxygen conserving device <input type="checkbox"/> Alarm system to monitor high risk respiratory member <input type="checkbox"/> Titration of liter flow <input type="checkbox"/> High altitude monitoring <input type="checkbox"/> Nocturnal Hypoventilation								
5. Describe recommended treatment when member desaturates. If other, explain.	<input type="checkbox"/> Titrate to greater than or equal to _____ % with exercise <input type="checkbox"/> If O2 sat is less than 90%, titrate liter flow to _____ <input type="checkbox"/> Other								
6. Supply any additional information that will assist us in determining medical necessity for this request:									

Print Prescriber Name _____

Prescriber Signature _____

Date _____

Revised June 2021

