S Y S T E M

| Patient Information |  |  | Order Date |  |
| :---: | :---: | :---: | :---: | :---: |
| Last Name | First Name |  |  | $M \square F \square$ |
| Medical Record \# | Phone |  | Date of Birth |  |
| Street | City | State |  | Zip |
| Primary Insurance |  | Secondary Insurance |  |  |
| Contact Name |  | Primary Language |  |  |
| Alt Phone |  | Email |  |  |
| Healthcare Facility |  | Phone |  |  |
| Fax |  | Anticipated Discharge Date |  |  |

BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY
(The prescriber must initial and date any revisions made after the prescriber has signed the order form)

| $R_{X}$ | Type | Description |  | HCPCS | Qty | Length of Time |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | MIE Therapy Device | BiWaze ${ }^{\text {TM }}$ Cough System |  | E0482 |  | Lifetime (99) Other: $\qquad$ |
|  | Patient Circuit Interface | Tracheostomy Mask <br> Circle Mask Size: Pediatric Adult Small | Adult Medium Adult Large | A7020 |  | Monthly <br> Other: |

Protocol: The standard protocol will be followed if any or all sections of the custom protocol are blank. Settings may be adjusted to patient comfort and/or with a peak cough flow goal >160 lpm. Auscultation of the upper airway may be performed to evaluate upper airway stability in patients with bulbar syndrome.

|  | Standard | Custom |
| :--- | :--- | :--- |
| Treatments/day | 2 |  |
| Inhale/Exhale Pressure | $(+/-) 5-70 \mathrm{~cm} \mathrm{~h}_{2} 0$ |  |
| Pause Pressure | $1-15 \mathrm{~cm} \mathrm{~h} \mathrm{~h}_{2} 0$ |  |
| Inhale/exhale/pause time | $0-5$ seconds |  |
| Comfort settings <br> (Inspiratory trigger, advanced settings, flow) | Adjust to patient comfort |  |
| Oscillation settings <br> (frequency and amplitude) | Adjust to patient comfort |  |

Diagnosis: List all primary, secondary, and underlying diagnosis that apply

| Diagnosis |  | Code | Diagnosis |  | Code |
| :--- | :--- | :--- | :--- | :--- | :--- |
| 1. |  |  | 3. |  |  |
| 2. |  | 4. |  |  |  |

I certify the information contained on this form is true, accurate, and complete to the best of my knowledge. This prescription is for the BiWaze ${ }^{\mathrm{TM}}$ Airway Clearance System and the patient circuit interface, which according to my professional judgement, is medically necessary for the patient identified above. The patient's record contains documentation supporting use of MI-E therapy and I agree to provide such documentation upon request. A copy of this order will be retained as part of the patient's medical record.

Prescriber's Signature: Date: $\qquad$
(Original signature and date required. Stamped signature and date not accepted.)
Prescriber's Printed Name: $\qquad$ NPI: $\qquad$

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