BiWaze® Clear SYSTEM

Prescription/Order Form

Patient Information							Order Date	
First & Last Name							M ☐ F ☐	
Medical Record #		Phone			Date of Birth			
Street		City		State		Zip		
Primary Insurance & ID#:			Secondary Insurance & ID#					
Contact Name			Primary Language					
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)

Relevant medical history in the past 12 months (check all that apply):

History of respiratory infections ☐ Atelectasis / lung collapse ☐ Mucus plugs ☐ Hospitalizations due to pulmonary exacerbations ☐
Inability to cough or clear secretions ☐ Decline in pulmonary function ☐ Other: ____

Select the methods of airway clearance the patient has tried and failed (check all that apply):

CPT (manual or percussor) ☐ High Frequency Chest Wall Oscillation ☐ Other Lung Therapy Techniques ☐

Select all the reasons why the above therapy failed or is contraindicated or inappropriate for this patient (check all that apply):

Physical limitations of caregiver ☐ Physical limitations of the patient ☐ Artificial airway ☐ Inadequate time for complete therapies ☐

Rx BiWaze Clear System (Oscillating lung expansion therapy system and supplies)

Type	Description	Length of Time
OLE Therapy System	BiWaze® Clear System	Lifetime (99) Other: ______
Dual Lumen Breathing Circuit Interface	Mouthpiece Tracheostomy Face Mask Child Adult Small Adult Medium Adult Large	Monthly 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.

Protocol	Standard	Custom
Treatments per Day	2	
Minutes per Treatment	10 (2.5 mins per phase)	
PEP pressure	5 - 30 cm h_20	
OSC pressure	10 - 30 cm h_20	
Oscillation frequency	Low, Medium, or High	
Nebulizer	PEP & OSC Phases	

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® Clear 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 OLE 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: ______________

(Original signature and date required. Stamped signature and date not accepted.)

Prescriber's Printed Name: ____ NPI:________________

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