BiWaze® Clear SYSTEM

Prescription Form

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

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)

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

Type	HCPCS	Description	Quantity	Length of Time
OLE Therapy System	E0469	BiWaze® Clear System	1	☐ Lifetime ☐ Other
Consumable Breathing Circuit with Patient Interface	A7021	☐ Mouthpiece ☐ Trach Adapter Face Mask ☐ Infant ☐ Child ☐ Adult Small ☐ Adult Medium ☐ Adult Large	1	☐ Monthly

List all relevant diagnosis that apply to OLE therapy

Diagnosis		ICD-10 Code
1.		
2.		
3.		
4.		
5.		
6.		

Select the Standard or Custom Protocol. Settings may be adjusted within the range provided based upon the clinician's discretion.

	☐ Standard Protocol	☐ Custom Protocol
Treatments per Day	2	
Minutes per Treatment	10 (2.5 mins per therapy phase/function)	
PEP Pressure	5 - 15 cm h_20	
OSC Pressure	10 - 30 cm h_20	
Oscillation Frequency	Medium	
Nebulizer	During both PEP & OSC phase/functions	
Other Protocol Notes:		

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 consumable breathing circuit, 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: _____

Prescriber's Printed Name: _____ NPI:_____

Prescribers Facility: _____

abm RESPIRATORY CARE