EnableNSW

# Nocturnal (Bilevel) Ventilation - Adult Equipment Request Form

### When to use this form

Use this form if you cannot submit this request using EnableNSW Online.

Find out more at www.enable.health.nsw.gov.au/online

### Filling in this form

You can complete this form on your computer or print and sign it. If you need to print this form ensure you:

- Use blue or black pen
- Print in BLOCK LETTERS
- Sign the prescriber declaration

### Eligibility

An EnableNSW application form is required to assess a person's eligibility. A new application form is required every two years **OR** if the person's circumstances change. Application forms can be accessed online at www.enable.health.nsw.gov.au/for_individuals/applying-to-EnableNSW. If we do not have an application form at the time of reviewing this request, the request may go on hold and delay the outcome.

### Important information before making this request

- You must be an eligible prescriber for this type of equipment **AND**,
- the equipment requested must meet the applicable funding criteria. You can read more about this at www.enable.health.nsw.gov.au/prescribers/forms
- Full technical and physician reports of all relevant tests must be submitted with this request.

### For more information

Go to our website www.enable.health.nsw.gov.au or call us on 1800 Enable (1800 362 253)

### Privacy

We collect your personal information and the health information of patients to allow EnableNSW to manage and provide its services. This allows us to:

- Assess your eligibility to prescribe assistive technology in accordance with the relevant funding criteria
- Contact you if more clinical information is required about the request, as well as provide status updates about the request
- Share contact details with a supplier if additional support is required for set up of equipment when necessary.

If you would like to view or make changes to your information, please send an email to enable@health.nsw.gov.au or call 1800 Enable (1800 362 253).

## A. Request type

☐ New request

## B. Person information

**1. Person details**

Title ☐ First name ☐ Surname ☐

Date of birth D D/M M/Y Y Y Y

Medicare card number ☐☐☐☐ ☐☐☐☐☐ ☐ Ref no. ☐

Person's address ☐

State Postcode

**2. Delivery details**

Where will the equipment be delivered to? *Select ONE option*

☐ Person's address ***Go to question 3***

☐ Other, please specify where the equipment will be delivered ☐

Contact name ☐ Contact phone number ( )

Delivery address (if not person's address) ☐

State Postcode

## C. Diagnosis

**3. What is the primary diagnosis in relation to the requested equipment?**

**4. Provide other relevant diagnosis/co-morbidities:**

## D. Patients requiring nocturnal bilevel ventilation / adaptive servo-ventilation equipment selection

**5. Are you requesting standard or non-standard equipment?**

☐ Standard nocturnal (bilevel) ventilation device:

*If standard selected, select ONE of the following devices:*

- ☐ ResMed Lumis S
- ☐ ResMed Lumis ST
- ☐ ResMed Lumis ST-A#

*(#For inspiratory pressures > 25 $cmH_2O$ or alarm requirements)*

**OR**

☐ Standard adaptive servo-ventilation device (for non-hypercapnic central sleep apnoea only):

*If adaptive servo-ventilation selected, select ONE of the following devices:*

- ☐ ResMed AirCurve 10 CS Pacewave

**OR**

☐ Non-standard nocturnal (bilevel) ventilation device:

*If non-standard selected, select ONE of the following devices and select reason/s below:*

☐ ResMed Stellar 150 ☐ Philips A40 Pro

*Reasons (select all that apply and/or outline rationale):*

- ☐ Required for nocturnal ventilation via a tracheostomy
- ☐ Nocturnal ventilation with specific device requirements (e.g. peak pressures >30$cmH_2O$)

*Outline rationale for non-standard device requirements:*

## E. External humidification requirements for invasive (tracheal) ventilation

**6. Does the patient require external humidification equipment and consumables for invasive ventilation?** *Select ONE option:*

☐ N/A – Patient uses mask ventilation and will receive an integrated humidifier

☐ Yes – Patient uses invasive (tracheal) ventilation and requires humidification equipment and consumables (ensure that the humidifier and respiratory consumables equipment request forms are completed)

☐ No – Patient uses invasive (tracheal) ventilation but does not require supply of external humidification equipment (a humidifier will not be provided)

## F. Bilevel diagnostic criteria

**7. Select ONE diagnostic pathway to use and complete the corresponding relevant section before moving to section G. Refer to the relevant Funding Criteria on the EnableNSW website:** www.enable.health.nsw.gov.au/prescribers/forms/hrp

☐ 7A - Obesity Hypoventilation Syndrome (OHS)

☐ 7B - Neuromuscular / neurodegenerative disease

☐ 7C - Chronic obstructive pulmonary disease (COPD)

☐ 7D - Other hypercapnic groups (non-COPD lung diseases, chest wall disorders, kyphoscoliosis or mixed diagnoses e.g. overlap syndrome)

☐ 7E – Non-hypercapnic central sleep apnoea (adaptive servo-ventilation)

**Complete the relevant diagnostic pathway you have selected in Question 7**

***7A – Obesity hypoventilation syndrome (OHS)***

Provide BMI (kg/m²) ☐, $PaCO_2$ (mmHg) ☐ **AND** pH ☐

**Select ONE diagnostic criteria AND attach all relevant sleep studies/oximetry, findings/reports and/or blood gas results:**

☐ OHS with stable $PaCO_2$ ≥ 52 mmHg

**OR**

☐ OHS with stable $PaCO_2$ 46-51 mmHg AND AHI/ODI < 30/hr. Provide AHI/ODI ☐

**OR**

☐ OHS with stable $PaCO_2$ 46-51 mmHg AND AHI/ODI ≥ 30/hr. Provide AHI/ODI ☐ **AND** complete ONE sub-section below:

☐ The patient has trialled CPAP, and CPAP was inadequate in controlling sleep-disordered breathing. *If selected confirm ALL of the following AND attach all relevant letters, sleep studies and/or blood gas results.*

- ☐ An in-lab CPAP titration has been performed
- ☐ Downloaded compliance report from a 4 week trial of CPAP attached
- ☐ Evidence of CPAP inadequacy is attached: i.e. $PaCO_2$ ≥ 46 mmHg after 4 week CPAP trial *OR* rise in transcutaneous $CO_2$ ≥ 8mmHg from baseline despite optimal CPAP *OR* sustained oxygen desaturation ($SpO_2$ ≤ 88% for ≥ 10 minutes) on CPAP in the absence of obstructive events.

Specify reason for CPAP inadequacy:

**OR**

☐ A trial of CPAP was not considered appropriate for the patient. Outline reasons CPAP was not trialled:

***7B – Neuromuscular / neurodegenerative disease***

**Select ONE or more diagnostic criteria AND attach all relevant sleep studies, other findings/reports and/or relevant blood gas results:**

☐ Letter attached documenting an acute event with respiratory de-compensation requiring hospitalisation where complete weaning was not possible

**OR**

☐ Vital Capacity (VC) ≤ 50% or maximal inspiratory pressure (MIP) ≤ 40 $cmH_2O$ or sniff nasal inspiratory pressure (SNIP) ≤ 40 $cmH_2O$.

Provide VC (%pred) ☐ or MIP ($cmH_2O$) ☐ or SNIP = ($cmH_2O$) ☐,

**OR**

☐ Diagnostic PSG or nocturnal respiratory monitoring demonstrating a fall in $SpO_2$ below 90% for more than 2% of total sleep time OR $TcCO_2$ ≥ 8 mmHg from baseline

**OR**

☐ ABG or capillary blood gases demonstrating awake $PCO_2$ ≥ 46 mmHg. Provide $PaCO_2$ ☐

**OR**

☐ Paired evening-morning ABGs demonstrating a $PaCO_2$ rise ≥ 8mmHg.

Provide pm $PaCO_2$ ☐ & am $PaCO_2$ ☐

**OR**

☐ **ADDITIONAL option for Rapidly Progressive Disorders**: VC ≤ 70% predicted OR MIP ≤ 60$cmH_2O$ OR SNIP ≤ 60$cmH_2O$.

Provide VC (%pred) ☐ or MIP ($cmH_2O$) ☐ or SNIP = ($cmH_2O$) ☐

**OR**

☐ **ADDITIONAL option for Rapidly Progressive Disorders**: Clinical letter attached documenting significant orthopnoea and daytime somnolence

***7C – Chronic obstructive pulmonary disease (COPD)***

**Select ONE diagnostic criteria AND attach all relevant clinical letter, sleep studies, other findings/reports and/or relevant blood gas results:**

☐ Stable ABG or capillary blood gases demonstrating awake $PCO_2$ ≥ 52mmHg and pH ≥ 7.35, ≥ 2 weeks following an acute exacerbation. Provide $PCO_2$ [ ] & pH [ ]

**OR**

☐ Clinical letter and supporting evidence (e.g. serial ABGs) outlining (during an acute hospital admission) non-invasive ventilation (NIV) could not be withdrawn without the person developing acute respiratory acidosis, at a time close to discharge and despite resolution of acute issues

**OR**

☐ Clinical letter and supportive evidence (e.g. serial ABGs) outlining readmission to hospital with acute hypercapnic respiratory failure within four weeks of withdrawing NIV during the previous admission to hospital

***7D – Other hypercapnic groups (non-COPD lung diseases, chest wall disorders, kyphoscoliosis or mixed diagnoses e.g. overlap syndrome)***

**Select ONE diagnostic criteria AND attach all relevant clinical letter, sleep studies, other findings/reports and/or relevant blood gas results.**

☐ ABG or capillary blood gases demonstrating awake $PCO_2$ ≥ 46 mmHg. Provide $PaCO_2$ [ ]

**OR**

☐ $PaCO_2$ rise ≥ 8 mmHg on paired evening-morning ABGs taken during a period of clinical stability.

Provide pm $PaCO_2$ [ ] & am $PaCO_2$ [ ]

**OR**

☐ $TcCO_2$ rise ≥ 8 mmHg from baseline during diagnostic PSG or nocturnal respiratory monitoring please attach relevant technical and physician report

***7E – Non-hypercapnic central sleep apnoea (adaptive servo-ventilation)***

**Complete Safety and Medical Optimisation, Diagnostic Criteria & Inadequacy of CPAP sections below:**

**Safety and Medical Optimisation**

**Regarding safety and medical optimisation for ASV treatment, confirm ALL of the following:**

☐ Recent echocardiogram attached confirming left ventricular ejection fraction (LVEF) > 45%. Physician must be satisfied that the echocardiogram report provided reflects the person's current ejection fraction.

Provide LVEF (%) [ ]

☐ I confirm that the medical management of the person's heart failure has been optimised

☐ I confirm that I have assessed the safety of the prescribed mode and settings for the person

**Diagnostic criteria**

**Select ONE of the diagnostic criteria below AND attach all relevant sleep studies:**

☐ Recent diagnostic PSG or nocturnal respiratory monitoring demonstrating central sleep apnoea (CSA)/Cheyne-Stokes Respiration (CSR) with AHI ≥ 20/hr in which at least 50% of events are central.

Provide AHI [ ] & Central Apnoea Index [ ]

**OR**

☐ Recent CPAP titration sleep study or nocturnal respiratory monitoring on CPAP demonstrating CSA/CSR with ongoing AHI ≥ 20/hr in which at least 50% of events are central

Provide AHI [ ] & Central Apnoea Index [ ]

**CPAP inadequacy for treatment of Non-Hypercapnic Central Sleep Apnoea**

**Select one or more of the options below to demonstrate inadequacy of CPAP treatment AND attach CPAP download and/or letter (if applicable):**

☐ Compliance report from a 2-4 week home trial of titrated fixed pressure CPAP attached, demonstrating that CSA/CSR is not resolved

**AND/OR**

☐ Letter attached outlining attempts to establish CPAP treatment and confirming a week trial of CPAP was not tolerated

## G. Nocturnal (bilevel) ventilation / adaptive servo-ventilation treatment pathways

**8. Select one treatment pathway AND attach all relevant sleep studies, other findings/reports and/or relevant blood gas results**

☐ Recent nocturnal ventilation / adaptive servo-ventilation titration PSG demonstrating adequate control of sleep disordered breathing and gas exchange on the prescribed mode and settings

**OR**

☐ Technical and physician report of overnight oximetry + detailed polygraphic data demonstrating adequate control of sleep disordered breathing and gas exchange on the prescribed mode and settings

**OR**

☐ *Additional pathway for COPD only:* Reduction on $PaCO_2$ of ≥ 4mmHg from stable baseline, after 2-4 weeks of bilevel AND detailed polygraphic data download demonstrating optimisation on prescribed bilevel mode and settings. Provide post treatment $PaCO_2$ ☐

## H. Nocturnal (bilevel) ventilation / adaptive servo-ventilation compliance report, safety and clinical letter

**9. Provide evidence of nocturnal (bilevel) ventilation home trial, compliance download, and clinical letter:** *Confirm ALL of the following AND attach relevant supporting documents*

☐ Trial of nocturnal ventilation / adaptive servo-ventilation at home for at least 2 consecutive weeks, demonstrating usage of ≥ 4 hours per night for ≥ 70% of nights

Provide percentage of nights used ≥ 4 hours (%) AND hours of usage (hours:min)

Percentage ☐ Hours:min ☐

☐ An individual care plan and an emergency plan have been documented and communicated to the person and their family/carer/s, to manage clinical and equipment emergencies and to allow the person to live safely in the community

☐ Recent clinical letter attached confirming that the person is clinically stable on long-term nocturnal (bilevel) ventilation / adaptive servo-ventilation, any relevant information to support the equipment request (including support for non-standard bilevel device selection) and who will be responsible for ongoing clinical review

Compliance report must be <4 months old. If ventilation usage is approaching 16 hours per day, consider a trial of equipment which has TGA certification for continuous use

## I. Nocturnal (bilevel) ventilation / adaptive servo-ventilation prescription, primary interface and oxygen entrainment

Please ensure a complete script is attached for the device and mode being selected. Script templates can be found on the EnableNSW Home Respiratory Program website www.enable.health.nsw.gov.au/prescribers/forms/home-respiratory-program-hrp/scripts. Please consult suppliers for additional scripts or information.

**10. Confirm complete script for device setup, with patient details, date and clinician signature is attached:**

☐ Yes

**11. Provide nocturnal (bilevel) ventilation mode:** *Select ONE option*

☐ Spontaneous
☐ Spontaneous-Timed
☐ Pressure Control
☐ Adaptive servo-ventilation
☐ Other – provide mode ☐

**12. Select the primary interface used with nocturnal bilevel ventilation:** *Select ONE option*

☐ Full face mask
☐ Nasal mask
☐ Nasal pillows
☐ Oral mask
☐ Tracheostomy

**13. Is supplemental oxygen entrained into the system?** *Select ONE option*

☐ No
☐ Yes – provide oxygen flow rate (L/min) ☐

***Go to next page and complete Section J. Prescriber eligibility and declaration***

## J. Prescriber eligibility and declaration

**14. Prescriber eligibility**

Confirm you have assessed the person and have the qualification and level of experience to prescribe this equipment in line with the relevant EnableNSW Funding Criteria and Professional Criteria for Prescribers.

☐ Yes

**15. Prescriber declaration**

**I confirm the following:**

- The person/carer agrees with this request
- A copy of this request will be provided to the person/carer
- As a health professional, I cannot also be the equipment supplier for the same request. This may include but is not limited to a personal or professional relationship with or material interest in the supplier or manufacturer of the equipment listed on this request

**I declare that:**

- I have the qualification and experience to prescribe this equipment or, I have been supervised by an eligible EnableNSW prescriber for this type of equipment
- All information I have supplied on this application is true and correct to the best of my knowledge at the time of assessment

**Prescriber information:**

Prescriber name

Place of work

Address

State Postcode

Qualification AHPRA registration number

Phone number ( ) Email

Signature Date D D/M M/Y Y Y Y

**16. Other contacts (optional)**

Complete this question if you would like to provide details of any other relevant health professionals who will be involved with the management and monitoring of the person's condition

**Other contact 1**

Name

Place of work

Address

State Postcode

Qualification AHPRA registration number

Phone number ( ) Email

**Other contact 2**

Name

Place of work

Address

State Postcode

Qualification AHPRA registration number

Phone number ( ) Email

**Submitting this request**

Submit this form and any relevant clinical documentation to enable@health.nsw.gov.au, please include the following in your subject line **Equipment type_Person name_Date submitted** *i.e Bilevel_Adult request_John Smith_01.01.2022*