EnableNSW

Nocturnal (Bilevel) Ventilation - Paediatric 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 diagnosis/es and clinical information related to the requested equipment?

4. Provide other relevant diagnosis/co-morbidities:

D. Weight

5. Provide the child's weight (kg):

E. Nocturnal bilevel ventilation equipment – intended use for weight and age

6. Select ONE relevant statement for paediatric nocturnal bilevel equipment intended use for weight and age:

☐ Device being prescribed within the manufacturer's intended use for weight and age

OR

☐ Device being prescribed OUTSIDE of manufacturer's intended use for weight and age. *If selected, confirm ALL of the following*:

- ☐ I have attached a letter acknowledging that I have individually assessed the patient **AND**
- ☐ I have considered the suitability and safety of a standard bilevel device for the patient **AND**
- ☐ This has been discussed with and consented by the child's family/guardian

F. Nocturnal bilevel ventilation equipment selection

7. Are you requesting standard or non-standard nocturnal bilevel ventilation 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

☐ Non-standard nocturnal (bilevel) ventilation device:

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

Nocturnal invasive: ☐ ResMed Stellar ☐ Philips A40 Pro

Continuous ventilators: ☐ ResMed Astral ☐ Philips Trilogy Evo

Reasons:

- ☐ Required for nocturnal ventilation via a tracheostomy
- ☐ Required to meet intended use for weight and age requirements

G. External humidification requirements for invasive (tracheal) ventilation

8. 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 all relevant respiratory consumable 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)

H. Bilevel diagnostic criteria

9. Select ONE of the diagnostic groups below based on the person's diagnosis and complete the relevant section

☐ **General Criteria.** *Complete ONE subsection below AND attach all relevant sleep studies, other findings/reports and/or relevant blood gas results:*

☐ **Confirmation of sleep hypoventilation by:**

☐ $PvCO_2$ ≥ 50mmHg on venous blood gas. Provide $PvCO_2$: ☐

OR

☐ $PaCO_2$ ≥ 45mmHg on blood gas (capillary or arterial). Provide $PaCO_2$: ☐

OR

☐ **Evidence of sleep hypoventilation on a diagnostic polysomnogram (PSG) or nocturnal respiratory monitoring (with sufficient sleep achieved) meeting one of the following criteria:**

☐ $TcCO_2$ > 50mmHg for 25% of the sleep study

OR

☐ $TcCO_2$ ≥ 8mmHg from baseline

OR

☐ $PaCO_2$ ≥ 8mmHg from paired evening-morning blood gas

OR

☐ **A diagnosis with predisposition to impaired central control of breathing:**

PLUS

☐ Central apnoea index ≥ 5/hr. Provide Central apnoea index: ☐ **AND**

☐ Significant oxygen desaturation: minimum SpO_2 85% OR repetitive desaturation to less than 90%

OR

☐ **Neuromuscular / neurodegenerative disorders.** *Select ONE below and provide relevant documentation to support:*

☐ Repeated respiratory admissions (e.g. two or more respiratory related admissions per year) or recurrent respiratory illnesses consistent with a decline in respiratory function, outlined in a letter from physician

OR

☐ An acute event with respiratory decompensation requiring hospitalisation where complete weaning off ventilatory support has not been possible

OR

☐ $TcCO_2$ rise >4mmHg during REM sleep

I. Nocturnal (bilevel) ventilation treatment criteria

10. Confirm the following AND attach the relevant nocturnal ventilation sleep study report/s:

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

J. Compliance report, safety and clinical letter

11. 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 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 ventilation, any relevant information to support the equipment request 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

K. Nocturnal (bilevel) 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

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

☐ Yes

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

☐ Spontaneous

☐ Spontaneous-timed

☐ Pressure control

☐ Other – provide mode ☐

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

☐ Full face mask

☐ Nasal mask

☐ Nasal pillows

☐ Oral mask

☐ Tracheostomy

15. Is supplemental oxygen entrained into the system?

☐ No

☐ Yes – provide oxygen flow rate (L/min) ☐

Go to next page and complete Section L. Prescriber eligibility and declaration

L. Prescriber eligibility and declaration

16. 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

17. 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

18. 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_Paediatric_request_John Smith_01.01.2022*