Medicare Checklist for AffloVest
(High Frequency Chest Wall Oscillation)

1 MEDICAL RECORD
Document the following:

■ Reason(s) for ordering AffloVest, such as:
  • Signs & Symptoms
    - Daily productive cough for at least 6 continuous months — or — Frequent (more than 2/year) exacerbations requiring antibiotic therapy
  • Diagnosis
    - Brochiectasis confirmed by a high resolution, spiral or standard CT scan — or — Cystic fibrosis
    - MS
    - MD
    - ALS
    - Other neuromuscular diseases
  ■ Failure of standard treatments to adequately mobilize retained secretions
    - Well-documented failure of treatment interventions (chest physiotherapy, postural drainage, medications used, mechanical modalities, etc) and the effectiveness of the treatment

■ Treatment plan
  - Recommendation for AffloVest or HFCWO

■ Practitioner signature
  - Signature must be legible or verified by signature log.
  - Medical records must be dated within 12 months prior to order.

2 WRITTEN ORDER
Prior to dispensing.

See Reverse for Order Form

3 FAX
Medical record and written order to:

Respiratory Care
5665 South Westridge Drive
New Berlin, WI 531510
Ph 262.786.9870 ext. 208
Fax 262-957-5535

The AffloVest is a physician prescribed oscillation treatment device. Respiratory patients should consult their physician to determine how AffloVest can help.

MEDICARE APPROVED DIAGNOSES FOR AFFLOVEST OR HFCWO EQUIPMENT

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>ICD-10 CODE</th>
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</thead>
<tbody>
<tr>
<td>CYSTIC FIBROSIS, UNSPECIFIED</td>
<td>E84.9</td>
</tr>
<tr>
<td>CYSTIC FIBROSIS WITH PULMONARY MANIFESTATIONS</td>
<td>E84.0</td>
</tr>
<tr>
<td>BRONCHIECTASIS WITH ACUTE LOWER RESPIRATORY INFECTION</td>
<td>J47.0</td>
</tr>
<tr>
<td>BRONCHIECTASIS WITH (ACUTE) EXACERBATION</td>
<td>J47.1</td>
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<tr>
<td>CONGENITAL BRONCHIECTASIS</td>
<td>Q33.4</td>
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<tr>
<td>BRONCHIECTASIS, UNCOMPlicated</td>
<td>J47.9</td>
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</table>

**NEUROMUSCULAR DISEASES**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>ICD-10 CODE</th>
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<tbody>
<tr>
<td>POST-POLIO SYNDROME</td>
<td>G14</td>
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<tr>
<td>GLYCOGEN STORAGE DISEASE DUE TO ACID MALTASE DEFICIENCY</td>
<td>E74.0</td>
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<tr>
<td>SPINAL MUSCULAR ATROPHY, UNSPECIFIED</td>
<td>G12.9</td>
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<tr>
<td>MULTIPLE SCLEROSIS</td>
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<tr>
<td>QUADRIPLEGIA, UNSPECIFIED</td>
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<tr>
<td>MUSCULAR DYSTROPHY</td>
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<tr>
<td>OTHER SPECIFIED MYOTONIC DISORDERS</td>
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<td>MYOPATHY, UNSPECIFIED</td>
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<tr>
<td>AMYOTROPIC LATERAL SCLEROSIS</td>
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<tr>
<td>DISORDERS OF DIAPHRAGM</td>
<td>J98.6</td>
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</tbody>
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Sources: Medicare LCDs for High Frequency Chest Wall Oscillation Devices; effective July 1, 2016.
Patient Information

Patient First Name

Patient Last Name

Gender

Date of Birth

Patient Phone Number

Patient Primary Insurance

Policy Number

Height / Weight

Narrative Diagnosis Descriptions & ICD-10 Codes

Patient Chest Circumference (nipple line) & Patient Torso Length (shoulder blade to waist / belt line)

Prescription / Written Order Prior to Delivery

Start Date: _______________ Length of Need: ☐ 30 Day Rx  ☐ 99 (Lifetime)  ☐ Other _______________

☐ Dispense one AffloVest by International Biophysics Corporation / High Frequency Chest Wall oscillation System / E0483

☐ Frequency of Use (standard): Use the AffloVest at 5Hz–20Hz for 30 minute treatments twice per day
   (minimum of 10 minutes per day)

☐ Frequency of Use (custom): Use the AffloVest at _______ Hz for _______ minutes treatments _________ per day.

__________________________
Physician Signature (stamped signature not accepted)

Date

__________________________
Physician Printed Name

NPI Number

I certify the accuracy of this Rx for the AffloVest Airway Clearance System and that I am the physician identified in this form. I certify that the medical information provided above and in the supplementary documentation is true, accurate, and completed to the best of my knowledge. The patient record contains the supplementary documentation to substantiate the medical necessity of the AffloVest and physician notes will be provided to the authorized AffloVest distributor by request. By providing this form to an authorized AffloVest distributor, I acknowledge that the patient is aware that he or she may be contacted by said distributor for any additional information to process this order.