AFFLOVEST® PRESCRIPTION AND WRITTEN ORDER

(High Frequency Chest Wall Oscillation E0483)

FAX: 866.569.1912

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Evening Phone: _____ Daytime Phone: _____

Email: _____ Date of Birth: _____ Gender: _____

ICD10 Diagnosis Code: _____ Primary Diagnosis: _____

Chest Circumference: _____
(Measure fullest part of chest)

Primary Insurance Provider: _____ Secondary Insurance Provider: _____

BELOW THIS LINE TO BE COMPLETED BY A HEALTHCARE PROVIDER ONLY

Airway Clearance Therapy Tried and Failed. This must be documented in the patient's progress notes.

1. Have alternative airway clearance techniques been **tried and failed**? ☐ YES ☐ NO

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

   ☐ CPT (manual or percussor) ☐ Oscillating PEP (Flutter, Acapella®, Aerobika®, Pep Valve, Pep Mask)
   ☐ Huff coughing ☐ Breathing techniques ☐ Mucomyst*
   ☐ Hypertonic saline ☐ Suctioning
   (*Notes must document it is prescribed for secretion mobilization)

2. Check all reasons why the above therapy failed, is contraindicated or inappropriate for this patient:

   ☐ Cannot tolerate positioning/hand CPT ☐ Too fragile for hand CPT ☐ Did not mobilize secretions ☐ Other
   ☐ Physical limitations of caregiver ☐ Caregiver unable to perform adequate CPT ☐ Insufficient expiratory force
   ☐ Gastroesophageal reflux (GERD) ☐ Severe arthritis, osteoporosis ☐ Resistance to therapy
   ☐ Cognitive level ☐ Unable to form mouth seal ☐ Artificial airway

3. For Cystic Fibrosis or Neuromuscular patients, the following must be documented in the patient's progress notes. Please attach records with Rx.

   ☐ Documentation supporting diagnosis ☐ Tried and failed a lesser airway clearance technique indicated above

4. For Bronchiectasis patients, please check Yes or No to the following question:

   Has there been a CT scan confirming Bronchiectasis diagnosis? ☐ YES ☐ NO If "Yes" please include copy of CT scan interpretation.

   In addition, the following medical history in the past year must be documented in the patient's progress notes. Please attach records with Rx.

   ☐ More than two exacerbations, i.e., lung infections, requiring antibiotics in the last 12 months, documented at least two separate times
   OR
   ☐ Daily productive cough for more than six continuous months

Rx: High Frequency Chest Wall Oscillation (HFCWO HCPCS E0483)

Start Date: _____ Check need of Length: ☐ Lifetime (99) ☐ Other _____

☐ Dispense one AffloVest by Tactile Medical/High Frequency Chest Wall Oscillation System/E0483
☐ Frequency of use (standard): Use the AffloVest at low, medium or high for 30 minute treatments twice per day
☐ Frequency of use (custom): Use the AffloVest at (**select a box**) ☐ low, ☐ medium or ☐ high for _____ minutes ____ times per day
☐ Please check box if nebulizer therapy to be used in conjunction with HFCWO

Physician Signature: _____ Date: _____

Physician Printed Name: _____ NPI Number: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Physician Phone: _____ Fax: _____

Alternate Contact: _____ Phone: _____ Email: _____

Designated DME: _____

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.

*AffloVest requires a doctor's prescription for treatment by High Frequency Chest Wall Oscillation (HFCWO). The AffloVest has received the FDA's 510k clearance for U.S. market availability, and is approved for Medicare, Medicaid and private health insurance reimbursement under the Healthcare Common Procedure Coding System (HCPCS) code E0483 – High Frequency Chest Wall Oscillation. The AffloVest is also available through the U.S. Department of Veterans Affairs/Tricare. Patients must qualify to meet insurance eligibility requirements.

Durable Medical Equipment companies are ultimately responsible for ensuring that the reimbursement criteria for a specific insurance plan and patient situation are satisfied.

Tactile Medical
3701 Wayzata Blvd, Suite 300 Toll Free Tel: 800.575.1900
Minneapolis, MN 55416 USA Toll Free Fax: 866.569.1912 afflovest.com

Tactile MEDICAL®

Medicare Approved ICD-10 Codes for AffloVest HFCWO Therapy (HCPCS E0483)

Medicare Requirements for Bronchiectasis:

1. Required: CT scan confirming diagnosis of bronchiectasis.

   AND

2. Required: Daily productive cough for more than six continuous months.

   OR

   Frequent (i.e., more than two/year) exacerbations requiring antibiotic therapy in the last 12 months.

   AND

3. Required: Documentation (chart notes) of another treatment tried to mobilize secretions and clearly indicating the other technique or device has failed.

ICD-10 CODE	DESCRIPTION
J47.0	Bronchiectasis with acute lower respiratory infection
J47.1	Bronchiectasis with (acute) exacerbation
J47.9	Bronchiectasis, uncomplicated
Q33.4	Congenital bronchiectasis

Medicare Requirements for Other Respiratory, Cystic Fibrosis and Neuromuscular Conditions*:

Physician's order that includes: AffloVest prescription, qualifying Dx, chart notes to support the Dx and well-documented failure of standard treatments to adequately mobilize retained secretions.

ICD-10 CODE/DESCRIPTION

Bronchiectasis
J47.0 Bronchiectasis with acute lower respiratory infection
J47.1 Bronchiectasis with (acute) exacerbation
J47.9 Bronchiectasis, uncomplicated
Q33.4 Congenital bronchiectasis

Cystic Fibrosis
E84.0 Cystic fibrosis with pulmonary manifestations
E84.9 Cystic fibrosis, unspecified

Infectious/Immune
A15.0 Tuberculosis of lung

Polyiomyelitis
B91 Sequelae of poliomyelitis
G14 Postpolio syndrome

Myotonic/Metabolic Disorders
E74.02 Pompe disease
E74.05 Lysosome-associated membrane protein 2 [LAMP2] deficiency
G71.11 Myotonic muscular dystrophy
G71.12 Myotonia congenita
G71.13 Myotonic chondrodystrophy
G71.14 Drug induced myotonia
G71.19 Other specified myotonic disorders

Motor Neuron/Neuromuscular/Anterior Horn Cell Disease
G12.0 Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
G12.1 Other inherited spinal muscular atrophy
G12.20 Motor neuron disease, unspecified
G12.21 Amyotrophic lateral sclerosis
G12.22 Progressive bulbar palsy
G12.23 Primary lateral sclerosis
G12.24 Familial motor neuron disease
G12.25 Progressive spinal muscle atrophy
G12.29 Other motor neuron disease
G12.8 Other spinal muscular atrophies and related syndromes
G12.9 Spinal muscular atrophy, unspecified

Multiple Sclerosis
G35.A Relapsing remitting MS
G35.B0 Primary progressive MS
G35.B1 Active primary progressive MS
G35.B2 Non-active primary progressive MS
G35.C0 Secondary progressive MS
G35.C1 Active secondary progressive MS
G35.C2 Non-active secondary progressive MS
G35.D Multiple sclerosis, unspecified

Muscular Dystrophy
G71.00 Muscular dystrophy, unspecified
G71.01 Duchenne or Becker muscular dystrophy
G71.02 Fascioscapulohumeral muscular dystrophy
G71.031 Autosomal dominant limb girdle muscular dystrophy
G71.032 Autosomal recessive limb girdle muscular dystrophy due to calpain-3 dysfunction
G71.033 Limb girdle muscular dystrophy due to dysferlin dysfunction
G71.0340 Limb girdle muscular dystrophy due to sarcoglycan dysfunction, unspecified
G71.0341 Limb girdle muscular dystrophy due to alpha sarcoglycan dysfunction
G71.0342 Limb girdle muscular dystrophy due to beta sarcoglycan dysfunction
G71.0349 Limb girdle muscular dystrophy due to other sarcoglycan dysfunction
G71.035 Limb girdle muscular dystrophy due to anoctamin-5 dysfunction
G71.036 Limb girdle muscular dystrophy due to fukutin related protein dysfunction
G71.038 Other limb girdle muscular dystrophy
G71.039 Limb girdle muscular dystrophy, unspecified
G71.09 Other specified muscular dystrophies

Disorders of the Diaphragm
J98.6 Disorders of diaphragm

Myopathies
G71.20 Congenital myopathy, unspecified
G71.21 Nemaline myopathy
G71.220 X-linked myotubular myopathy
G71.228 Other centronuclear myopathy
G71.29 Other congenital myopathy
G71.3 Mitochondrial myopathy, not elsewhere classified
G71.8 Other primary disorders of muscles
G72.0 Drug-induced myopathy
G72.1 Alcoholic myopathy
G72.2 Myopathy due to other toxic agents
G72.41 Inclusion body myositis [IBM]
G72.49 Other inflammatory and immune myopathies, not elsewhere classified
G72.89 Other specified myopathies
G72.9 Myopathy, unspecified
G73.7 Myopathy in diseases classified elsewhere
M33.02 Juvenile dermatomyositis with myopathy
M33.12 Other dermatomyositis with myopathy
M33.22 Polymyositis with myopathy
M33.92 Dermatopolymyositis, unspecified with myopathy
M34.82 Systemic sclerosis with myopathy
M35.03 Sicca syndrome with myopathy

Quadriplegia
G80.0 Spastic quadriplegic cerebral palsy
G82.50 Quadriplegia, unspecified
G82.51 Quadriplegia, C1-C4 complete
G82.52 Quadriplegia, C1-C4 incomplete
G82.53 Quadriplegia, C5-C7 complete
G82.54 Quadriplegia, C5-C7 incomplete

Myasthenia Gravis
G70.00 Myasthenia gravis without acute exacerbation
G70.01 Myasthenia gravis with acute exacerbation

*cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33785&ContrID=140

Tactile Medical
3701 Wayzata Blvd, Suite 300 Toll Free Tel: 800.575.1900
Minneapolis, MN 55416 USA Toll Free Fax: 866.569.1912 afflovest.com

Tactile MEDICAL®