Prior Authorization Request
5802 Benjamin Center Dr., Suite 105
Tampa, FL 33634

**ColoradoPAR Program**
Medical Review Department

Phone: 1-888-801-9355
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# QUESTIONNAIRE #8
# CPAP/ Bi- Level (PAP) – ADULT 21+

| Client Name: | | Colorado Medicaid ID #: | |
|---|---|---|---|

| Height: | | Weight: | |
|---|---|---|---|

The information requested below is required to determine medical necessity. After you have completed this form, attach it to the completed Prior Authorization Request (PAR).

| | |
|---|---|
| 1) Date of sleep study:<br>(Sleep study must have been completed within 1 year of PAR start date and a copy submitted with the PAR.) | |
| 2) Apnea Hypopnea Index (AHI) results:<br>AHI of 15 or greater client will qualify.<br><br>a.) If AHI between 5 and 14 client must have diagnosis of one of the following:<br><br>(Clients that have AHI of 4 or less do not qualify for CPAP.) | ☐Daytime sleepiness ☐Mood disorders ☐Hypertension<br>☐ Impaired Cognition ☐ Insomnia<br>☐ Ischemic heart disease |
| 3) If it is Bi-PAP being ordered for condition other than Obstructive Sleep Apnea, sleep study not required.<br><br>a.) ☐ Restrictive Lung Disease<br><br>☐ Neuromuscular Disease<br><br>☐ COPD | PaCO2 _____ On _____ Liters per minute (lpm) or room air test done on usual FiO2<br>Saturation of _____ % for 5 continuous minutes on _____ lpm.<br><br>Maximum Inspiratory Pressure _____ or Forced Vital Capacity _____ %<br><br>PaCO2 _____ On _____ Liters per minute (lpm) or room air test done on usual FiO2<br>Saturation of _____ % for 5 continuous minutes on _____ lpm.<br><br>OSA ruled out: ☐Yes ☐ No CPAP ruled out: ☐Yes ☐ No |
| 4) Please supply any additional information that will assist us in determining **medical necessity** for your request: | |

***Note: Children 20 and under do not require questionnaire.**

Print Prescriber Name _____

Prescriber Signature _____ Date _____



Revision Date: 09/15