EnableNSW

# Oxygen - Adult Long Term Oxygen Therapy (LTOT) 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

### 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).

**Adult LTOT** – use this form if oxygen is still required after completing an initial short term oxygen therapy (STOT) trial post hospital discharge OR stable community hypoxaemia is diagnosed

### Registering the device with the person's electricity provider
As part of the person's emergency plan, please ensure they have contacted their electricity provider and registered details about their life support medical device. This should ensure the person receives adequate support during power outages. Additionally, the rebate form through Service NSW can be completed to assist with the cost of living www.service.nsw.gov.au/transaction/apply-for-the-life-support-energy-rebate-retail-customers

## A. Request type

☐ New request ☐ Amendment to existing 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?**

- ☐ Bronchiectasis
- ☐ COPD
- ☐ Interstitial lung disease
- ☐ Cardiac failure intractable
- ☐ COVID-19 -pneumonitis/long COVID
- ☐ Pulmonary fibrosis
- ☐ Congenital cardiac disease
- ☐ Cystic fibrosis
- ☐ Pulmonary hypertension
- ☐ Other

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

## D. Equipment specification

**5. Select one stationary oxygen concentrator and specify flow rate:** *Select ONE option*

- ☐ Oxygen concentrator standard flow (0 - 5 L/min). Flow rate (L/min)
- ☐ Oxygen concentrator high flow (6 – 10 L/min). Flow rate (L/min)
- ☐ No oxygen concentrator requested

**6. Select C size cylinders and specify flow rate:** *Select ONE option*

- ☐ Portable oxygen C cylinders x2 with standard regulator x1. Flow rate (L/min)
- ☐ Portable oxygen C cylinders x2 with conserver regulator x1. Flow rate (L/min)
- ☐ No portable cylinders requested

**7. Does the person use continuous oxygen (≥ 16 hours/day) AND reside > 2 hours from their closest hospital?**

- ☐ No
- ☐ Yes – provide D Cylinder. Flow rate (L/min)

## E. Current supplier of home oxygen

**8. Does the person currently receive supply of home oxygen (e.g. hospital discharge supply)?** *Select ONE option*

- ☐ No
- ☐ Yes - Initial oxygen supplied by BOC
- ☐ Yes - Initial oxygen supplied by Supagas

## F. Long term oxygen assessment date

**9. Outpatient / long term oxygen assessment date** D D/M M/Y Y Y Y

## G. Stability, compliance and ongoing follow-up

**10. Confirm ALL of the following have been addressed:**

- ☐ The person's condition is stable and requires long term oxygen therapy for management in the home
- ☐ The person is aware that they will not be eligible for funding if they smoke
- ☐ Recommended oxygen equipment is compatible with the person's living environment
- ☐ The person is aware that data regarding oxygen therapy usage will be collected by the supplier and can be obtained by the prescriber and EnableNSW
- ☐ Annual review for ongoing oxygen requirements has been arranged

## H. Eligibility: oxygen concentrator

**11. Select ONE of the oxygen usage requirements and complete the relevant criteria below:**

☐ **Prescription is ≥ 16 hours/day**

Choose one criteria, ensure stable ABG is attached and provide $PaO_2$ ____

☐ Daytime $PaO_2$ ≤ 55 mmHg **OR**

☐ Daytime $PaO_2$ 56–59 mmHg plus written evidence of significant end-organ damage due to one or more of the following: pulmonary hypertension, right heart failure, polycythaemia or other. *Specify evidence below:*

**OR**

☐ **Prescription is ≥ 6 hours/day (for nocturnal hypoxaemia)**

*Confirm one from EACH category (Dx - Diagnostic criteria, Evidence of improvement and Positive Airway Pressure (PAP) intolerance). Attach any supporting test results, ABG, and clinical reports/letters*

☐ Dx: $SpO_2$ ≤ 88% for ≥ 30% (attach technical and physician report of polysomnogram or nocturnal oximetry)

**OR**

☐ Dx: $SpO_2$ ≤ 80% for ≥ 10% of sleep time (attach technical and physician report of polysomnogram or nocturnal oximetry)

**OR**

☐ Dx: Significant nocturnal desaturation AND evidence of hypoxia-related sequelae (polycythaemia, right heart failure or pulmonary hypertension) (attach technical and physician report of polysomnogram or nocturnal oximetry and provide letter of justification)

**AND**

☐ Evidence of improvement: provide technical and physician report of polysomnogram or nocturnal/continuous oximetry demonstrating objective improvement in $SpO_2$ on supplemental oxygen (copy attached)

**AND**

☐ PAP intolerance: Is the person unable to tolerate PAP and prescribed oxygen as an alternative treatment for sleep-disordered breathing?

- ☐ N/A
- ☐ Yes - provide letter of justification

**OR**

☐ **Prescription is ≥ 6 hours/day (for Central Sleep Apnoea related to Congestive Heart Failure)**

*Confirm one from EACH category (Dx, PAP trial and evidence of improvement). Attach any supporting test results, ABG, and clinical reports/letters*

☐ Dx: Diagnostic polysomnogram (including technical and physician's report) demonstrating apnoea hypopnoea index (AHI) > 20/hour, with central sleep apnoea (CSA) for a majority (> 50%) of events (copy attached)

**AND**

☐ PAP trial: CPAP titration polysomnogram (including technical and physician's report) demonstrating residual AHI > 15/hour on CPAP (copy attached)

**OR**

☐ PAP trial: Letter of justification provided by the prescribing physician outlining why the person is unable to tolerate positive airway pressure therapy (copy attached)

**AND**

☐ Evidence of improvement: polysomnogram (including technical and physician's report) demonstrating AHI<15/hour OR a 50% reduction in central events on titrated oxygen therapy (copy attached)

## I. Improvement and stability on titrated oxygen flow rate

**12. Confirm stability and safety on prescribed oxygen:**

☐ The person's oxygen flow rate has been adequately titrated to ensure $SpO_2$ is maintained within a safe target range for the person, and to avoid worsening hypercapnia

## J. Eligibility: portable cylinder oxygen (C cylinders)

**13. Confirm ONE of the following:**

☐ Prescription is ≥ 16 hours/day

☐ Prescription is <16 hours/day

*If <16 hours/day selected, confirm ALL the following and attach clinical letter and 6 minute walk tests*

☐ Diagnosis of interstitial lung disease or other non-COPD lung disease

**OR**

☐ Respiratory diagnosis with evidence of hypoxia-related sequelae (polycythaemia, right heart failure, pulmonary hypertension), provided in a clinical letter of justification.

**AND**

☐ Evidence of significant desaturation during exercise ($SpO_2$ <88%) while breathing room air

**AND**

☐ Distance walked in 6 minute walk test while on oxygen improves by ≥ 25m OR by > 50% in people with baseline 6 minute walk distance < 50m

☐ N/A - Portable Cylinder Oxygen is not requested

## K. Funding portable oxygen cylinder refills

**14. Confirm the following for portable oxygen cylinder requests:**

☐ The person is aware of and willing to partially fund the therapy including charges for portable C cylinder refills and delivery charges

☐ N/A - Portable Cylinder Oxygen is not requested

## L. Community safety, training and emergency plan

**15. Confirm ALL of the following three criteria demonstrating adequate community safety, carer training and provision of an emergency plan have been addressed:**

☐ A risk assessment has been conducted and documented, and the person can be safely managed on the prescribed equipment in the community

☐ The person and family/carer/s have received adequate training, and have acknowledged the risks and responsibility for safely managing the person and the equipment in the community

☐ 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

## M. Ongoing monitoring and assessment

**16. Provide the details of the eligible clinician/prescriber who will continue to monitor the person:** *Select ONE option*

☐ The prescriber for this request (Respiratory/Palliative Care Physician) will assess and monitor the person's condition

☐ A different eligible prescriber (Respiratory/Palliative Care Physician) will assess and monitor the person's condition

*Provide name, qualification, phone number, email address and clinical service:*

| |
|---|
| |
| |

☐ An eligible Nurse Practitioner will assess and monitor the person's condition, working in collaboration with a Respiratory or Palliative Care Physician

*Provide name, qualification, phone number, email address and clinical service, and name of the Respiratory or Palliative Care Physician:*

| |
|---|
| |
| |

☐ Requests from other prescribers, such as general practitioners or physicians, will only be considered in rural or remote areas, where an eligible prescriber (Respiratory Physician, Palliative Care Physician or Respiratory Nurse Practitioner) is unavailable within the health service/ Local Health District.

If this is the case, with each application the prescriber must provide a letter:

☐ Outlining the reasons why an eligible prescriber is not available **AND**

*Provide name, qualification, phone number, email address of the clinician responsible for follow-up and ongoing respiratory care of the person:*

| |
|---|
| |
| |

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

## N. Prescriber eligibility and declaration

**17. 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

**18. 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

**19. 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 Oxygen_Adult_LTOT_request_John Smith_01.01.2022*