EnableNSW
Adult CPAP 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, 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/hrp
- 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 health information of patients to allow EnableNSW to provide its services and use the information 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
- Share contact details with a supplier if additional support is required for set up of equipment if it is 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. Diagnostic and clinical information

3. What is the primary diagnosis in relation to the requested equipment?

4. Provide other relevant diagnosis/co-morbidities

D. Patients requiring CPAP via a Standard or Non-Standard bilevel device

5. Are you requesting a Standard/Non-Standard bilevel device to be set in CPAP mode?

☐ No - A standard fixed pressure CPAP device is being requested *(select one of the following devices)*:

☐ Standard CPAP: ResMed Airsense 10 Elite

☐ Yes - CPAP delivered via tracheostomy – *indicate device below and ensure the relevant script is attached*

☐ Yes - Patient requires CPAP at pressures >20cmH_2O – *indicate the device below and ensure the relevant script is attached*

If yes selected above, provide device name:

E. CPAP diagnostic criteria

6. Select ONE diagnostic criteria AND attach the relevant sleep studies AND provide relevant diagnostic ODI / AHI / $PaCO_2$ value in text box below:

☐ ODI ≥ 30/hr — Provide diagnostic ODI

☐ AHI ≥ 30/hr on diagnostic polysomnogram (PSG) — Provide Diagnostic AHI

☐ AHI ≥ 20/hr on diagnostic polysomnogram (PSG) — Provide Diagnostic AHI

If AHI 20-29/hr, select ONE option AND attach the relevant sleep studies and/or letter with clinical information

☐ Pulmonary hypertension, congestive heart failure, drug resistant hypertension or stroke

☐ Central sleep apnoea (CSA)/ Cheyne Stokes Respiration (CSR) for the majority (≥ 50%) of respiratory events

☐ Evidence of hypoventilation / daytime hypercapnia:

Select ONE option AND attach the relevant sleep studies and/or letter with clinical information

☐ Stable awake $PaCO_2$ ≥ 46 mmHg — Provide $PaCO_2$

☐ Overnight rise in $PaCO_2$ of ≥ 8 mmHg — Provide pm $PaCO_2$ — Provide am $PaCO_2$

☐ Evidence of hypoventilation / daytime hypercapnia: $TcCO_2$ rising ≥ 8 mmHg from baseline on PSG

F. Screening - comorbidities/ risk factors for hypoventilation

7. Does the person have any of the below comorbidities/ risk factors for hypoventilation: *Select one or more*

If you select any risk factor/co-morbidities, only follow the CPAP pressure determination PSG treatment pathway or complicated/complex diagnosis treatment pathway in **question 8**.

☐ N/A - Patient does not have any of the below risk factors/co-morbidities

☐ COPD

☐ Requires supplemental oxygen

☐ Awake SpO_2 ≤ 92% / hypercapnia

☐ Hypoventilation syndrome

☐ BMI ≥ 45kg/m^2

☐ Heart failure

☐ Chronic opioid use

☐ Neuromuscular or chest wall deformity

☐ Other significant sleep, respiratory or cardiac disorders (including CSA/CSR)

G. CPAP treatment requirements

8. Select ONE option AND attach the relevant CPAP titration sleep study reports or Auto-titrating CPAP download, AND other relevant tests/correspondence, and/or current clinical justification letter

☐ **All diagnosis pathways:** CPAP pressure determination (PD) PSG demonstrating control of sleep-disordered breathing (SDB)

OR

☐ **Uncomplicated diagnosis pathway (recent):** Auto-titrating CPAP treatment trial for ≥ 3 consecutive nights to determine the fixed pressure AND demonstrating a reduction in AHI to ≤10/hr.

Provide treatment AHI ☐

OR

☐ **Uncomplicated diagnosis pathway (established):** Person has been established on CPAP for > 5 years and is currently using CPAP. Provide clinical letter confirming that there has been no significant change in the person's respiratory/sleep condition since establishment on CPAP

OR

☐ **Complicated/complex diagnosis pathway (*only if CPAP PD cannot be arranged*)** Auto-titrating CPAP treatment trial for ≥ 3 consecutive nights to determine the fixed pressure AND demonstrating a reduction in AHI to ≤10/hr.

Provide treatment AHI ☐ AND

If this pathway is chosen, confirm ALL of the below and attach relevant supporting documents

- ☐ I have assessed the safety of CPAP for the person
- ☐ I have attached a letter attached outlining the person's clinical history and the reasons why a CPAP PD was not performed
- ☐ I have attached oximetry with detailed download on prescribed fixed CPAP demonstrating stable gas exchange (including full technical and physician report)
- ☐ The person's resting SpO_2 is >93% on room air OR serum bicarbonate <27 mmol/L OR arterial or capillary blood gas PCO_2 is ≤45 mmHg.

Provide resting SpO_2 ☐ OR serum bicarbonate ☐ OR PCO_2 ☐

H. Compliance report and clinical letter

9. Confirm ALL of the following AND attach relevant supporting documents *Note: CPAP trial report must be within last 4 months*

☐ Trial of fixed pressure CPAP 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 per night (hours:min)

Percentage ☐ Hours:min ☐

☐ Recent clinical letter confirming that the person is clinically stable on long-term CPAP AND who will be responsible for ongoing review

I. CPAP device settings

10. Provide CPAP fixed pressure (cmH_2O) ☐

11. Ramp: on/off

☐ Off ☐ On - Provide ramp time ☐ and starting pressure (cmH_2O) ☐

12. Is pressure relief on exhalation required (e.g. EPR, C-Flex, softPAP)?

☐ No ☐ Yes - Provide pressure relief on exhalation settings:

For ResMed devices indicate if EPR is: ☐ Ramp only OR ☐ Full-time

13. Provide any other CPAP device or humidifier settings

J.Primary interface and oxygen entrainment

14. **What is the primary interface used with CPAP therapy?**

☐ Full face mask ☐ Nasal mask ☐ Nasal pillows ☐ Oral mask ☐ Tracheostomy

15. **Is supplemental oxygen entrained into the system?**

☐ No ☐ Yes - Provide flow rate (L/min) _____

Go to next page and complete Section K. Prescriber Eligibility and Declaration

K. 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

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 *CPAP request_John Smith_01.01.2022*