BiWaze[®] Clear

Consumable

with Patient

Interface

Breathing Circuit

A7021

Prescription Form

Patient Information				Order Date				
First & Last Name								
Medical Record #		Phone				Date of Birth		
Street		City			State		Zip	
Primary Insurance & ID#:			Secondary Insurance & ID#					
Email			Primary Lan	guage				
Alt Patient Contact Name			Alt Patient C	ontact F	Phone			

BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

(The prescriber must initial and date any revisions made after the prescriber has signed the order form)

Rx BiWaze Clear System (Oscillating lung expansion therapy system and supplies) List all relevant diagnosis that apply to OLE therapy Length of Time Туре **HCPCS** Description Quantity 🔲 Lifetime **OLE Therapy** E0469 BiWaze® Clear System 1 System Other Mouthpiece

Trach Adapter

Face Mask

Adult Small

🗖 Adult Medium

Adult Large

🗖 Infant

Child

Select the Standard or Custom Protocol. Settings may be adjusted within the range provided based upon the clinician's discretion.

1

	Standard Protocol	Custom Protocol
Treatments per Day	2	
Minutes per Treatment	10 (2.5 mins per therapy phase/function)	
PEP Pressure	5 - 15 cm h ₂ 0	
OSC Pressure	10 - 30 cm h₂0	
Oscillation Frequency	Medium	
Nebulizer	During both PEP & OSC phase/functions	
Other Protocol Notes:		

Monthly

I certify the information contained on this form is true, accurate, and complete to the best of my knowledge. This prescription is for the BiWaze[®] Clear and the consumable breathing circuit, which according to my professional judgement, is medically necessary for the patient identified above. The patient's record contains documentation supporting use of OLE therapy and I agree to provide such documentation upon request. A copy of this order will be retained as part of the patient's medical record.

Prescriber's Signature:	Date:	
Prescriber's Printed Name:	NPI:	
Prescribers Facility:		

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