Spiro PD 2.0 Referral Form

For Cystic Fibrosis Patients

V.06.01.21.A

RemetricHealth
bringing healthcare home

Phone: 484-664-7600 Fax: 484-664-7500

Patient Demographics

Name: _____ ☐M ☐F
DOB: _____ SS#: _____
Phone: _____ 2nd Phone: _____
Email: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary language, if other than English: _____

Authorized alternate contact information
Name/relation: _____
Phone: _____ Email: _____

Provider Information

Prescriber: _____
_____
Phone: _____ Fax: _____
Facility/Clinic Name:_____
Address: _____
_____
NPI: _____ Office contact: _____

Training by: ☐ Prescriber's office ☐RemetricHealth ☐ Not needed

****Please fax a copy (front and back) of the patient's insurance card(s) as well as any relevant clinical notes/documents****

Clinical Information

Diagnosis:
☐ Cystic Fibrosis, unspecified (E84.9)
☐ Other _____

Clinical Info/Comments:
_____
_____

Device(s) Ordered

☐ **Spiro PD 2.0 Personal Spirometer** – personal digital spirometer, mouthpiece, stand, and charging cord (Quantity #1)

Provider Signature: _____ **Date:** _____

My signature for this prescription also authorizes RemetricHealth and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process. Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error please notify the sender noted above and destroy all transmitted material.

Statement of Medical Necessity

Patients with cystic fibrosis (CF) suffer frequent pulmonary exacerbations, diagnosed by a decline in lung function and an increase in exacerbation symptoms, such as cough, chest congestion, and increased sputum production. Early and aggressive therapy after exacerbation is associated with improved patient outcomes, however reliance on the patient to self-report possible exacerbation symptoms can delay appropriate therapy. CF patients do not typically monitor lung function at home and can neglect important signs and symptoms that may lead to the initiation of early and aggressive therapy.

In a study, conducted by West N.E, et. al., patient at-home monitoring was implemented with an electronic spirometer device for measuring FEV1 twice daily and exacerbation symptoms once daily. Results were transmitted weekly to the provider. The study found that exacerbations can be detected more than 2 weeks sooner than patient-reported symptoms and early treatment led to decreased use of both IV and oral antibiotics. There was also clinically meaningful improvement of 5% in FEV1 among electronic spirometer patients. Another study, by Fullmer J, et. al., implemented the Spiro PD home spirometer in CF patients finding the patients were comfortable with performing at-home spirometry and the use significantly improved adherence to CF respiratory medications. Use of the at-home spirometer has great potential to improve outcomes and medication adherence in CF patients, as well as providing spirometry results directly to the provider.

Personal spirometers with the ability for remote monitoring by healthcare professionals can provide numerous benefits to the patient outcome along with potential for economic advantages in containing exacerbation costs for CF patients. Providing the patient with this personal spirometer is a medical necessity to improve adherence with respiratory medications and to provide increased monitoring of pulmonary exacerbations to providers.

_____ (patient name) **is being treated under a comprehensive care plan for their cystic fibrosis. I certify that the device ordered above** (Spiro PD 2.0 personal spirometer) **is a medically necessary component of the patient's overall treatment and medical well-being.**

Provider Signature	**Date**
X	
Printed Name	