Spiro PD 2.0 Referral Form

For Lung Transplant Recipients

Phone: 877-385-0535 Fax: 877-326-2856

OptiMed SPECIALTY PHARMACY PMD Healthcare

Patient Demographics

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

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

Provider Information

Prescriber: _____
_____
Phone: _____ Fax: _____
Facility/Clinic Name:_____
Address: _____
_____
NPI: _____ Office contact: _____
Training to be performed by:
☐ Prescriber's office ☐ PMD Healthcare ☐ Not needed

Clinical Information

Diagnosis:
☐ Lung Transplant (Z94.2)

Clinical Info/Comments:
_____
_____

Clinical Support*

☐Patient to be enrolled in OptiMed's monitoring services and specialty pharmacy medication management*

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 OptiMed Health Partners 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.

*Clinical support service includes monitoring of lung function through the PMD portal in conjunction with the provision of specialty pharmacy medication management (clinical pharmacist review, proactive refill management and adherence support, and insurance benefit investigation, financial assistance, compliance and adherence packaging as needed).

Statement of Medical Necessity

Daily home monitoring of lung function (FEV1 and FVC) with a personal spirometer is a medical necessity for patients after lung transplantation to detect the early signs of acute and chronic lung rejection, respiratory infection, and other complications that may lead to emergency room visits, hospitalization, graft loss or death. Studies have demonstrated that proactive monitoring of the patient's lung function can allow for early detection of lung rejection and can provide economic benefits by decreasing medical costs.

Daily spirometry monitoring is also vital at later time points after transplantation. FEV1 has been identified as the most reliable diagnostic tool for detecting the onset of bronchiolitis obliterans syndrome (BOS) and other types of chronic lung allograft dysfunction (CLAD). BOS is the leading cause of late mortality and morbidity after lung transplantation and the primary indication for re-transplantation. Approximately 50% of patients experience BOS within 5 years following transplantation. Median survival after diagnosis is between 3 and 5 years. Home spirometry monitoring is essential for early recognition of BOS, treatment initiation and monitoring response to treatment.

Personal spirometers with the ability for remote monitoring by healthcare professionals provide numerous patient-centered outcome benefits as well as economic benefits in lung transplant recipients. In a study performed by the University of Minnesota, Adam et al. showed that adherence to home monitoring following lung transplant resulted in substantial cost savings by reducing inpatient costs by up to 72.24%, with 100% patient adherence. The average first year adherence was 74%, but only a 25.28% adherence rate was required to breakeven.

Providing the patient with this personal spirometer is a medical necessity to prevent hospitalization, transplant rejection, and death.

_____ (patient name) **is being treated under a comprehensive care plan following their lung transplant. 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	