COLORADO
Department of Health Care Policy & Financing

Acentra HEALTH

Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219	**ColoradoPAR Program** Medical Review Department	Phone: 1-720-689-6340 Fax: 1-800-922-3508

QUESTIONNAIRE #6
PULSE OXIMETER - ADULT 21+

Member Name		Health First Colorado ID #	

Length of Need		End Date		Height		Weight	

The information requested below is required to determine medical necessity. Complete this form and attach to the completed Prior Authorization Request (PAR).

1. What is the complete diagnosis with complicating factors? **Note**: If COPD is the primary diagnosis, additional respiratory diagnosis is required.	
2. Is the member on oxygen? If yes, how many liters per minute (lpm)?	□ Yes □ No _____ lpm □ Continuous □ Nocturnal Only □ Exercise Only
3. Is the pulse oximeter request for? If spot check, provide the member's last three dates and readings.	□ Spot Check Monitoring □ Continuous Monitoring **Date** | | | | **Reading** | | | |
4. What are the underlying conditions/circumstances that indicates the need for a continuous pulse oximeter? **Note**: Only one needed to qualify.	□ Monitor desaturation with/without oxygen conserving device □ Alarm system to monitor high risk respiratory member □ Titration of liter flow □ High altitude monitoring □ Nocturnal Hypoventilation
5. Describe recommended treatment when member desaturates. If other, explain.	□ Titrate to greater than or equal to □ % with exercise □ If O2 sat is less than 90%, titrate liter flow to □ Other
6. Supply any additional information that will assist us in determining **medical necessity** for this request:	

Print Prescriber Name _____

Prescriber Signature _____

Date _____