Prior Authorization Request 5802 Benjamin Center Dr., Suite 105 Tampa, FL 33634	**ColoradoPAR Program** Medical Review Department	Phone: 1-888-801-9355 Fax: 1-866-940-4288

QUESTIONNAIRE #6
PULSE OXIMETER – ADULT 21+

Client Name:		Colorado Medicaid ID #:	

Length of Need:		Height:	
		Weight:	

The information requested below is required to determine medical necessity. After you have completed this form, attach it to the completed Prior Authorization Request (PAR).

Question	Response
1) What is the complete diagnosis with complicating factors: (If COPD is the primary diagnosis, additional respiratory diagnosis is required)	
2) Is the client on oxygen? a.) If yes, how many liters per minute (lpm)?	☐Yes ☐No _________ lpm ☐ Continuous ☐ Nocturnal Only ☐ Exercise Only
3) Is the pulse oximeter being requested for: a.) If the pulse oximeter is being requested for spot check monitoring; please provide the client's last three readings and dates.	☐ Spot Check Monitoring ☐ Continuous Monitoring **Date:** ___ ___ ___ **Reading:** ___ ___ ___
4) Underlying conditions/circumstances that indicates the need for a continuous pulse oximeter (only one needed to qualify):	☐ Monitor desaturation with/without oxygen conserving device ☐ Alarm system to monitor high risk respiratory client ☐ Titration of liter flow ☐ High altitude monitoring ☐ Nocturnal Hypoventilation
5) Describe recommended treatment when client desaturates. a.) If other, please explain.	☐ Titrate to greater than or equal to ☐ % with exercise ☐ If O_2 sat is less than 90%, titrate liter flow to ☐ Other:
6) Please supply any additional information that will assist us in determining **medical necessity** for your request:	

***Note: Children 20 and under do not require questionnaire.**

Print Prescriber Name ______________________________

Prescriber Signature ______________________________ Date ______________

Revision Date: 09/15