QUESTIONNAIRE #7
APNEA MONITOR

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<th>Member Name</th>
<th>Health First Colorado ID #</th>
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<tr>
<th>Length of Need</th>
<th>End Date</th>
<th>Height</th>
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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?

2. How frequently do apneic episodes occur?
   Dates:

3. Is apnea monitoring?  □ Continuous  □ At night only  □ During feedings

4. List all documented apneic episodes during the initial 6-month monitoring period.

5. Has the member been hospitalized due to apneic episodes or related diagnosis?  □ Yes  □ No
   If yes, what dates?

6. Does the member use oxygen?  □ Yes  □ No
   If yes, what is the flow?

7. Supply any additional information that will assist us in determining medical necessity for this request:

Print Prescriber Name ____________________________________________________________

Prescriber Signature ____________________________________________________________

Date ____________________________________________

Revised June 2021

Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

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