



Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219

ColoradoPAR Program

Phone: 1-720-689-6340

Medical Review Department

Fax: 1-800-922-3508

QUESTIONNAIRE #8 CPAP/ Bi- Level (PAP) - ADULT 21+

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Member Nam	e			Health First Cold	orado ID #			
Length of Need		End Date		Height		Weight		
	on requested bed Prior Authoriza	•		medical necessit	ry. Complete	this form	and attach to	0
1. Date been	of sleep study. N completed withir y submitted with	lote: The sleep son one year of PA	study must hav					
great	a Hypopnea Inde er member will q nember must hav	Daytime Si	 □ Daytime Sleepiness □ Mood Disorders □ Hypertension □ Impaired Cognition □ Insomnia □ Ischemic Heart Disease 					
Note	: Members that I y for CPAP.	·						
Obstr	If Bi-PAP is being ordered for condition instead of Obstructive Sleep Apnea, then the sleep study is not required.			PaCO2	On		Liters per minut (lpm) or room air test don on usual FiO2	
□ Re	strictive Lung Dis	sease		Saturation of Maximum	% for 5 continu minutes	ous s on	lpm	
□ Ne	□ Neuromuscular Disease				Or Forc Capacit		%	
□ CC	PD			PaCO2	On		Liter (lpm) or room on usual FiO2	rs per minut air test don
				Saturation of	% for 5 continu minutes	ous	lpm	
4. Suppl	y any additional		OSA Ruled Out: Yes No CPAP Ruled Out: Yes No					
	mining medical							
Print Prescribe	r Name							
Prescriber Sign	nature							
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Revised May 2025