AFFLOVEST®
by Tactile Medical

RX ORDER CHECK LIST/FAX COVER SHEET

FAX: 866.569.1912

To	AffloVest Orders	Facility Name	
Fax		Sender Name	
Date		Sender Phone	
Re:	Prescription for AffloVest	Sender Email	
		# of Pages	

PLEASE INCLUDE THE FOLLOWING ITEMS (if applicable):

- ☐ **Physician Signed and Dated Prescription with physician NPI**
- ☐ Patient Demographics/Face Sheet
- ☐ Copy of Patient's Insurance Card(s) (front and back)
- ☐ Medical Records for the past 6 months, including any referral letters and hospital discharge summaries

PLEASE NOTE: The following items must be documented in the patient's medical record to support the prescription for vest therapy:

- Face-to-face encounter (Must be on or during the 6 months prior to the date of the vest therapy prescription)
- Other airway clearance treatment option that was tried and why it failed **OR** an airway clearance treatment option that was considered and why it was not an appropriate option.

☐ **FOR BRONCHIECTASIS PATIENTS:**

- Chest CT scan confirming diagnosis (Include CT scan report)
- Documentation in medical record of:
  - A) Daily productive cough for at least 6 continuous months (Example: "Patient reports daily productive cough in excess of six months"): **OR**
  - B) Pulmonary exacerbation requiring antibiotic therapy at least 3 times within the last year

NOTE: The diagnosis of bronchiectasis must be based on a CT scan. If the diagnosis of bronchiectasis does not appear in the radiology report, a pulmonologist's diagnosis of bronchiectasis may be sufficient, provided it is specifically based on and references the scan provided and those findings are included in a provided progress note.

Example: "Reviewed CT scan done on XX/XX/XX and find evidence of bronchiectasis present."

QUESTIONS? Call AffloVest at 800.575.1900

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