PRESCRIPTION / ORDER FORM - Monarch™ Airway Clearance System

Patient Name: ____________________________
(Required - please print) First Middle Last
Birth Date: ___ / ___ / ___ Gender: □ M □ F Primary Language: ____________________________

Street ____________________________ City State Zip ____________________________

Primary Insurance & ID#: ____________________________ Secondary Insurance & ID#: ____________________________

Patient Contact Name: ____________________________ Relationship to Patient: ____________________________
Phone: _______ □ H □ C □ W Alt Phone: _______ □ H □ C □ W E-mail: ____________________________

Chest Measurement: ____________________________

Date patient last seen: ___________ Is the patient currently in the hospital? □ N □ Y Discharge Date: ___________

BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY
(The prescriber must initial and date any revisions made after the prescriber has signed the order form)

1. □ Y □ N Have alternative airway clearance techniques been tried and failed?
   Please indicate methods of airway clearance patient has tried and failed (check all applicable boxes below):
   □ CPT (manual or percussor) □ Oscillating PEP □ PEP □ Other □ Cannot use other methods
   Check all reasons why the above therapy failed or is contraindicated or inappropriate for this patient:
   □ Physical limitations of caregiver □ Feeding tubes □ Unable to form mouth seal □ Severe arthritis, osteoporosis
   □ Gastroesophageal reflux (GERD) □ Aspiration risk □ Insufficient expiratory force □ Did not mobilize secretions
   □ Spasticity/contractures □ Kyphosis/scoliosis □ Artificial airway □ Young age
   □ Resistance to therapy □ Cognitive level □ Unable to tolerate positioning/percussion

2. □ Y □ N Has there been daily productive cough for at least 6 months?

3. Relevant medical history in past year (check all applicable boxes below):
   □ History of respiratory infections □ Hospitalizations due to pulmonary exacerbation □ Sputum cultured positive for resistant bacteria
   □ Atelectasis □ ER visits due to pulmonary exacerbation □ More than 2 exacerbations requiring antibiotic therapy in the last year:
   □ Mucus plugs □ Decline in pulmonary function □ IV antibiotics □ Oral antibiotics

4. For Bronchiectasis patient, please check Yes or No to the following question:
   □ Y □ N Has there been a CT scan confirming Bronchiectasis diagnosis? If Yes, please attach required report.

Clinic Information:
Name: ____________________________
Address: ____________________________
City: ____________________________ State: ____________________________ Zip: ____________________________
Phone: ____________________________ Fax: ____________________________

1. Signature Date (Required - MM/DD/YY)
2. Prescriber’s Signature (Required - no stamped signatures accepted)
3. Print Prescriber’s First and Last Name (Required)
4. NPI Number (Required)

Please include documentation of a Face to Face encounter with the patient for a medical condition that supports the need for the device. This is required before device shipment.

Rx Monarch™ Airway Clearance System
Including Replacement Batteries

PROTOCOL
Please Note: The Standard Protocol is used if any or all sections of the Custom Protocol are left blank.

<table>
<thead>
<tr>
<th>Treatments per Day</th>
<th>Standard</th>
<th>Custom</th>
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<table>
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<th>Minutes per Treatment</th>
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<th>Minimum Minutes of Use per Day</th>
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<table>
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<th>Length of Use Need</th>
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<tbody>
<tr>
<td>99 months = Lifetime</td>
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Other Protocol Notes:

Fax to 1.800.870.8452, with Face Sheet, Copy of Insurance Card, and Medical Records
Offered by Advanced Respiratory Inc., a Hill-Rom Company, 1020 West County Road F, St. Paul, MN 55126, Phone: 1.800.426.4224 www.respiratorycare.hill-rom.com

Revised 02/2017