smartvest®
AIRWAY CLEARANCE SYSTEM

BY ELECTROMED, INC.

Outsmart Bronchiectasis — Managing Symptoms with SmartVest

Whether it's symptoms like chronic productive cough, recurring respiratory infections, or shortness of breath, it may be time to talk to your doctor about bronchiectasis.

What is Bronchiectasis?

Bronchiectasis (brong-kee-EK-tuh-sis) is an irreversible, chronic condition where airways in the lungs (bronchi) become damaged and abnormally widened from recurring inflammation or infection, preventing your lungs from properly functioning. With bronchiectasis, your airways slowly lose their ability to clear out mucus, which creates an environment vulnerable to infection. Each recurring infection causes more damage to your airways, which over time impairs their ability to move air in and out.

What is SmartVest?

Clearing excess mucus from your lungs with a combination of medication and airway clearance techniques is one of the most common ways to improve symptoms and reduce complications of bronchiectasis. For some patients, these methods aren't enough to provide relief. That's when the **SmartVest Airway Clearance System** can be an effective, convenient, and comfortable solution to managing bronchiectasis.

The SmartVest Airway Clearance System uses high frequency chest wall oscillation, also known as "HFCWO," to help mobilize mucus out of your lungs. SmartVest delivers rapidly repeating pulses of air that squeeze and release your upper body. These gentle, yet powerful "mini coughs" loosen, thin, and propel mucus towards major airways in your lungs, where it can be more readily expectorated.

SmartVest is effective, convenient, easy to use, and comfortable.

In two recently published case review outcome-based studies, the SmartVest system was found to significantly reduce hospitalizations, repeat antibiotic treatments, emergency department visits, and respective healthcare costs.[1,2]

Is the SmartVest Right for Me?

Talk to your doctor about if and when the SmartVest system might be appropriate for you or your loved one. Take the SmartVest prescription and certificate of medical necessity form with you to your doctor to have a discussion about the benefits HFCWO therapy offers.

Discover all the unique benefits of the SmartVest Airway Clearance System by Electromed here and read about ways the SmartVest system has made a difference for patients and caregivers alike.

57% reduction in antibiotic prescriptions

59% decrease in hospitalizations

60% fewer emergency department visits

$3,045[1,2] overall annual savings in healthcare costs

1. Sievert CE *et al. Respiratory Therapy Journal. 2017*;12(1): 45-49
2. Sievert CE *et al. Respiratory Therapy Journal. 2016*;11(4): 34-38

ELECTROMED, INC.
Making life's important moments possible — one breath at a time.®
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AIRWAY CLEARANCE SYSTEM

Prescription and Certificate of Medical Necessity

Please attach **Patient Demographic/Face Sheet**, **Copy of Insurance Card**, **signed Patient Agreement Form** and **Medical Records**.
FAX all documents to **866-758-5077.** Questions? Please call **Electromed, Inc.** at 800-462-1045**.**

Name: (Last) ________________________ (First) ________________________ (Middle Initial) ________

Street________________________ City________________________ State________ Zip__________

Evening Phone: ____________________ Daytime Phone: ____________________ Cellular: ____________________

Date of Birth: ____________________ Primary Language: ____________________ SS#:____________________ M☐ F☐

Primary Diagnosis: ____ Code: ______________

Secondary Diagnosis: ____ Code: ______________

For Garment sizing: Height:____________________ Weight: ________________ Chest Circumference: ____________________

Airway Clearance Therapy Tried and Failed. This must be documented in the patient's progress notes.

☐ CPT (Manual or Percussor) ☐ Oscillating PEP ☐ Flutter/Acapella ☐ Suctioning
☐ Breathing Techniques ☐ Cough Assist ☐ Autogenic Drainage ☐ Cannot Use Other Forms

Check all reasons why the above therapy failed, is contraindicated or inappropriate for this patient.

☐ Unable to tolerate positioning/percussion ☐ No caregiver available ☐ Physical limitations of caregiver
☐ Severe arthritis/osteoporosis ☐ Cognitive level ☐ Physical limitations of patient
☐ Gastroesophageal reflux (GERD) ☐ Aspiration risk ☐ Kyphosis/scoliosis
☐ Spasticity/contractures ☐ Resistance to therapy ☐ Too fragile for percussion
☐ Feeding tube ☐ Young age ☐ Unable to form mouth seal
☐ Did not mobilize secretions ☐ Artificial airway ☐ Insufficient expiratory force

Medical History in The Past Year. This must be documented in the patient's progress notes.

☐ Hospitalizations due to pulmonary exacerbation ☐ Mucus Plugs ☐ ER visits due to pulmonary exacerbation
☐ History of respiratory infections ☐ Atelectasis ☐ Sputum tested positive for resistant bacteria
☐ 3 exacerbations requiring antibiotics ☐ IV antibiotics ☐ Oral antibiotics
☐ Y ☐ N Daily productive cough for at least 6 months ☐ Decline in Pulmonary function/ PFTs - Current FEV1: ____________________

If Bronchiectasis, is there a CT scan confirming diagnosis? ☐ Y **(attach report)** ☐ N **Date of last Face-to-Face Encounter:** __________

Physician Statement of Medical Necessity: ____

____

Rx: SmartVest® Airway Clearance System, HCPCS: E0483

Qty: 1/999 **Length of need:** 99 **Protocol:** Tx/Day – 2. **Frequencies** – 6 to 16 HZ. **Minutes per frequency** – 5 to 10.
Pressure to be set and adjusted per patient comfort and therapeutic benefit Minimum use per day – 15 minutes. Use settings best tolerated by patient.

I certify that this standard Rx is for the SmartVest® Airway Clearance System for Lifetime use. I certify that I am the physician identified in this form. I have reviewed all sections of the physician's written order. Any statement on my letterhead attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate, and complete to the best of my knowledge. I certify that the patient/caregiver is capable and has or will complete training in utilizing the products prescribed in this Written Order. The patient's record contains supporting documentation which substantiates the utilization and medical necessity of the products listed and physician notes will be provided to Electromed and/or an authorized distributor upon request. I understand any falsification, omission or concealment of material fact may subject me to civil or criminal liability. By faxing this form I am acknowledging that the patient is aware that Electromed and/or an authorized distributor may be contacting them for any additional information to process this order. A copy of this order will be retained as part of the patient's medical record.

____ ______________
Physician Signature (stamped signature not accepted) Date

____ ______________
Physician Name (print) NPI

______________ ______________ ______________
Contact Phone Fax

____
Institution

____
Address

Individualized Protocol

(Takes Precedence if completed)

____
Tx/day

____
Frequencies

____
Minute/Frequency

____
Minimum use/Day