THE OHIO STATE UNIVERSITY
HEALTH PLAN

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Columbus, OH 43202
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Bronchial Thermoplasty Request Form

Member Name:	ID Number:	DOB:
Physician:	Phone:	Fax:
Facility:	CPT Code(s):	ICD-10-CM:

Please provide the following documentation l·yŘ ₪Ŝűdz₪y₮2₪Y ű2 h{¦ l Ŝl·fűK tfl·y džáyƎ űKŜ ₮l·ÈΣ ŜY l·ńΣ 2₪ ¦{t{ ńy₮2₪Y l·úń2y ťłáúŜŘ l·ō2ØŜ:

- ☐ History & Physical
- ☐ Evaluation by a pulmonologist
- ☐ Pulmonary Function Test
- ☐ An assessment of asthma control using one of the following validated instruments: ACT, ATAQ, ACQ

- ☐ Progress notes documenting:
  - o Frequency of rescue inhaler use (include both days/week and nights/month)
  - o Exacerbations requiring oral steroids
  - o Side effects of medications (if applicable)
  - o Medication regimen
  - o Comorbidities

Does the member have any of the following contraindications?

- ☐ Pacemaker, internal defibrillator or implantable electronic device
- ☐ Known coagulopathy
- ☐ Known sensitivity to the medications used to perform bronchoscopy (such as lidocaine, atropine, benzodiazepines)
- ☐ Previous bronchial thermoplasty treatment
- ☐ Unstable co-morbid conditions presenting risk for bronchoscopy)
- ☐ Pregnancy
- ☐ Inability to stop anticoagulants or antiplatelet agents prior to the procedure

Printed Name of Pulmonologist: _____

Signature of Pulmonologist: _____