



# Authorization Request Form - Part 2

## Cardiac Ablation

Complete and fax the clinical worksheet immediately following the authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

**i** Please fill in each question option completely  →

<b>Patient Information</b>	First name	Last name	
	Member ID	Date of birth (MM/DD/YYYY)	

Fill out the following section if submitting for any of the following: **Adult Congenital Heart Disease**

<b>Question 1</b>	<p>What kind of request is this?</p> <p><input type="radio"/> This is the patient's first request for cardiac ablation. <input type="radio"/> This is a subsequent request for cardiac ablation.</p>																				
<b>Question 2</b>	<p>Which of the following findings were documented at the most recent encounter?</p> <p><input type="checkbox"/> Paroxysmal atrial fibrillation <input type="checkbox"/> None of the above</p> <p><input type="checkbox"/> Persistent atrial fibrillation</p>																				
<b>Question 3</b>	<p>Is the patient taking a class I or III antiarrhythmic?</p> <p><input type="radio"/> Yes, and the medication is effective. <input type="radio"/> No, the patient was not able to tolerate the medication.</p> <p><input type="radio"/> Yes, the patient is taking a class I or III antiarrhythmics, but it is not effective. <input type="radio"/> No, the patient is not taking a class I or III antiarrhythmic.</p> <p><input type="radio"/> No, the patient was taken off rhythm control medications after their initial procedure.</p>																				
<b>Question 4</b>	<p>Do any of the following apply to the patient?</p> <p><input type="checkbox"/> The patient has an Ebstein's anomaly for ablation of clinical or inducible reentrant tachycardia, high-risk pathway conduction, or multiple accessory pathways. <input type="checkbox"/> The patient requires a preoperative assessment of Tetralogy of Fallot (TOF) for sustained monomorphic ventricular tachycardia.</p> <p><input type="checkbox"/> The patient has recently had a Fontan palliation and intra-atrial reentrant tachycardia or focal atrial tachycardia. <input type="checkbox"/> The patient has recently had a Mustard/Senning operation with intra-atrial reentrant tachycardia or focal atrial tachycardia.</p> <p><input type="checkbox"/> None of the above</p>																				
<b>Question 4</b>	<p>Has the patient had recurrent episodes of symptomatic atrial fibrillation greater than three months after the initial procedure?</p> <p><input type="radio"/> Yes <input type="radio"/> No, this is the patient's first request for cardiac ablation.</p> <p><input type="radio"/> No</p>																				
<b>Question 5</b>	<p>Does the patient have any of the following surgical risk factors? (additional information)</p> <table border="0"> <tr> <td><input type="checkbox"/> Active bacterial infection</td> <td><input type="checkbox"/> Active smoking/nicotine use: enroll patient in a smoking cessation program</td> <td><input type="checkbox"/> Active drug or alcohol abuse</td> <td rowspan="5">Cardiovascular Disease (any of the following): acute coronary symptoms, uncompensated Congestive Heart Failure (CHF), uncontrolled arrhythmia, uncontrolled hypertension (greater than 180/110 mm Hg), severe valvular disease, percutaneous coronary intervention (PCI) within 1 month</td> </tr> <tr> <td><input type="checkbox"/> *Morbid Obesity (BMI greater than 40); refer for weight loss management</td> <td><input type="checkbox"/> Advanced Renal Disease (creatinine greater than 2)</td> <td><input type="checkbox"/> Coagulopathy or on anticoagulant therapy</td> </tr> <tr> <td><input type="checkbox"/> Primary pulmonary hypertension</td> <td><input type="checkbox"/> Anemia – Hemoglobin less than 11 (females 11, males 12)</td> <td><input type="checkbox"/> Diabetes – HbA1c greater than or equal to 8%</td> </tr> <tr> <td><input type="checkbox"/> End Stage Liver Disease</td> <td><input type="checkbox"/> Uncontrolled Seizure Disorder</td> <td><input type="checkbox"/> History of Malignant Hyperthermia/Heat stroke</td> </tr> <tr> <td><input type="checkbox"/> Known allergy or hypersensitivity to medication needed for procedure</td> <td><input type="checkbox"/> Trans Ischemic Attack (TIA) or stroke within past three months</td> <td><input type="checkbox"/> Obstructive Sleep Apnea – NOT treated with CPAP: Refer the patient for Sleep Apnea Treatment</td> </tr> <tr> <td><input type="checkbox"/> Oxygen-dependent pulmonary disease</td> <td></td> <td><input type="checkbox"/> CPAP: Refer the patient for Sleep Apnea Treatment</td> <td><input type="checkbox"/> None of the above</td> </tr> </table>	<input type="checkbox"/> Active bacterial infection	<input type="checkbox"/> Active smoking/nicotine use: enroll patient in a smoking cessation program	<input type="checkbox"/> Active drug or alcohol abuse	Cardiovascular Disease (any of the following): acute coronary symptoms, uncompensated Congestive Heart Failure (CHF), uncontrolled arrhythmia, uncontrolled hypertension (greater than 180/110 mm Hg), severe valvular disease, percutaneous coronary intervention (PCI) within 1 month	<input type="checkbox"/> *Morbid Obesity (BMI greater than 40); refer for weight loss management	<input type="checkbox"/> Advanced Renal Disease (creatinine greater than 2)	<input type="checkbox"/> Coagulopathy or on anticoagulant therapy	<input type="checkbox"/> Primary pulmonary hypertension	<input type="checkbox"/> Anemia – Hemoglobin less than 11 (females 11, males 12)	<input type="checkbox"/> Diabetes – HbA1c greater than or equal to 8%	<input type="checkbox"/> End Stage Liver Disease	<input type="checkbox"/> Uncontrolled Seizure Disorder	<input type="checkbox"/> History of Malignant Hyperthermia/Heat stroke	<input type="checkbox"/> Known allergy or hypersensitivity to medication needed for procedure	<input type="checkbox"/> Trans Ischemic Attack (TIA) or stroke within past three months	<input type="checkbox"/> Obstructive Sleep Apnea – NOT treated with CPAP: Refer the patient for Sleep Apnea Treatment	<input type="checkbox"/> Oxygen-dependent pulmonary disease		<input type="checkbox"/> CPAP: Refer the patient for Sleep Apnea Treatment	<input type="checkbox"/> None of the above
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## Authorization Request Form - Part 2 Cardiac Ablation

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<b>Patient Information</b>	First name	Last name
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Fill out the following section if submitting for any of the following: **Ventricular Arrhythmia**

<b>Question 1</b>	<p><b>Which of the following findings were documented within the past 3 months?</b></p> <table border="0"> <tr> <td><input type="checkbox"/> Symptomatic Premature Ventricular Complexes (PVCs) in a patient refractory to or intolerant to antiarrhythmic therapy</td> <td><input type="checkbox"/> Recurrent sustained monomorphic ventricular tachycardia (VT) in a patient refractory to or intolerance to antiarrhythmic therapy</td> </tr> <tr> <td><input type="checkbox"/> High-frequency Premature Ventricular Complexes (PVCs) with symptoms or diminished left ventricular (LV) function (LVEF less than or equal to 50%)</td> <td><input type="checkbox"/> Nonischemic cardiomyopathy with ventricular tachycardia (VT) storm</td> </tr> <tr> <td><input type="checkbox"/> Premature Ventricular Complex (PVC) is a trigger for other arrhythmias</td> <td><input type="checkbox"/> Sustained monomorphic ventricular tachycardia (VT) in repaired Tetralogy of Fallot</td> </tr> <tr> <td><input type="checkbox"/> Frequent Premature Ventricular Complexes (PVCs) interfering with biventricular pacing</td> <td><input type="checkbox"/> ACHD with sustained ventricular tachycardia (VT) (with all previous interventions ineffective)</td> </tr> <tr> <td><input type="checkbox"/> Sustained symptomatic monomorphic ventricular tachycardia (VT)</td> <td><input type="checkbox"/> Episodes of VT causing excess appropriate ICD shocks (e.g. in ARVC, Brugada Syndrome, sarcoidosis)</td> </tr> <tr> <td></td> <td><input type="checkbox"/> None of the above</td> </tr> </table>	<input type="checkbox"/> Symptomatic Premature Ventricular Complexes (PVCs) in a patient refractory to or intolerant to antiarrhythmic therapy	<input type="checkbox"/> Recurrent sustained monomorphic ventricular tachycardia (VT) in a patient refractory to or intolerance to antiarrhythmic therapy	<input type="checkbox"/> High-frequency Premature Ventricular Complexes (PVCs) with symptoms or diminished left ventricular (LV) function (LVEF less than or equal to 50%)	<input type="checkbox"/> Nonischemic cardiomyopathy with ventricular tachycardia (VT) storm	<input type="checkbox"/> Premature Ventricular Complex (PVC) is a trigger for other arrhythmias	<input type="checkbox"/> Sustained monomorphic ventricular tachycardia (VT) in repaired Tetralogy of Fallot	<input type="checkbox"/> Frequent Premature Ventricular Complexes (PVCs) interfering with biventricular pacing	<input type="checkbox"/> ACHD with sustained ventricular tachycardia (VT) (with all previous interventions ineffective)	<input type="checkbox"/> Sustained symptomatic monomorphic ventricular tachycardia (VT)	<input type="checkbox"/> Episodes of VT causing excess appropriate ICD shocks (e.g. in ARVC, Brugada Syndrome, sarcoidosis)		<input type="checkbox"/> None of the above
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<b>Question 2</b>	<p><b>Is cardiac ablation being considered for any of the following reasons?</b></p> <table border="0"> <tr> <td><input type="checkbox"/> Infrequent nonsustained ventricular tachycardia (VT)</td> <td><input type="checkbox"/> Patient has experienced a ventricular fibrillation (VF) arrest.</td> </tr> <tr> <td><input type="checkbox"/> Torsades de Pointes or other sustained polymorphic ventricular tachycardia (VT)</td> <td><input type="checkbox"/> None of the above</td> </tr> </table>	<input type="checkbox"/> Infrequent nonsustained ventricular tachycardia (VT)	<input type="checkbox"/> Patient has experienced a ventricular fibrillation (VF) arrest.	<input type="checkbox"/> Torsades de Pointes or other sustained polymorphic ventricular tachycardia (VT)	<input type="checkbox"/> None of the above								
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Fill out the following section if submitting for any of the following: **Supraventricular Tachycardia**

<b>Question 1</b>	<p><b>Is this request for the evaluation of an asymptomatic patient with ventricular preexcitation?</b></p> <table border="0"> <tr> <td><input type="radio"/> Yes, to determine the inducibility of atrioventricular reentrant tachycardia (AVRT).</td> <td><input type="radio"/> Yes, the patient presents with Syncope or Presyncope WITH AND WITHOUT exertion.</td> </tr> <tr> <td><input type="radio"/> Yes, to determine the rapidity of antegrade conduction as a risk factor for sudden cardiac arrest.</td> <td><input type="radio"/> None of the above</td> </tr> </table>	<input type="radio"/> Yes, to determine the inducibility of atrioventricular reentrant tachycardia (AVRT).	<input type="radio"/> Yes, the patient presents with Syncope or Presyncope WITH AND WITHOUT exertion.	<input type="radio"/> Yes, to determine the rapidity of antegrade conduction as a risk factor for sudden cardiac arrest.	<input type="radio"/> None of the above																
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<b>Question 2</b>	<p><b>Does the patient have any of the following conditions?</b></p> <table border="0"> <tr> <td><input type="radio"/> Symptomatic supraventricular tachycardia</td> <td><input type="radio"/> Any episode of preexcited atrial fibrillation</td> </tr> <tr> <td><input type="radio"/> Sustained supraventricular tachycardia</td> <td><input type="radio"/> A focal atrial tachycardia that may be caused by a new cardiomyopathy</td> </tr> <tr> <td><input type="radio"/> Wolff-Parkinson-White syndrome and syncope</td> <td><input type="radio"/> None of the above</td> </tr> </table>	<input type="radio"/> Symptomatic supraventricular tachycardia	<input type="radio"/> Any episode of preexcited atrial fibrillation	<input type="radio"/> Sustained supraventricular tachycardia	<input type="radio"/> A focal atrial tachycardia that may be caused by a new cardiomyopathy	<input type="radio"/> Wolff-Parkinson-White syndrome and syncope	<input type="radio"/> None of the above														
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<b>Question 3</b>	<p><b>Is this request to confirm the presence of ventricular preexcitation, which would interfere with certain types of employment (e.g., pilots, military service)?</b></p> <p><input type="radio"/> Yes      <input type="radio"/> No</p>																				
<b>Question 4</b>	<p><b>Does the patient have nonsustained, asymptomatic supraventricular tachycardia?</b></p> <p><input type="radio"/> Yes      <input type="radio"/> No</p>																				
<b>Question 5</b>	<p><b>Does the patient have any of the following surgical risk factors? (additional information)</b></p> <table border="0"> <tr> <td><input type="checkbox"/> Active bacterial infection</td> <td><input type="checkbox"/> Active smoking/nicotine use: enroll patient in a smoking cessation program</td> <td><input type="checkbox"/> Active drug or alcohol abuse</td> <td rowspan="5">Cardiovascular Disease (any of the following): acute coronary symptoms, uncompensated Congestive Heart Failure (CHF), uncontrolled arrhythmia, uncontrolled hypertension (greater than 180/110 mm Hg), severe valvular disease, percutaneous coronary intervention (PCI) within 1 month</td> </tr> <tr> <td><input type="checkbox"/> *Morbid Obesity (BMI greater than 40); refer for weight loss management</td> <td><input type="checkbox"/> Advanced Renal Disease (creatinine greater than 2)</td> <td><input type="checkbox"/> Coagulopathy or on anticoagulant therapy</td> </tr> <tr> <td><input type="checkbox"/> Primary pulmonary hypertension</td> <td><input type="checkbox"/> Anemia – Hemoglobin less than 11 (females 11, males 12)</td> <td><input type="checkbox"/> Diabetes – HbA1c greater than or equal to 8%</td> </tr> <tr> <td><input type="checkbox"/> End Stage Liver Disease</td> <td><input type="checkbox"/> Uncontrolled Seizure Disorder</td> <td><input type="checkbox"/> History of Malignant Hyperthermia/Heat stroke</td> </tr> <tr> <td><input type="checkbox"/> Known allergy or hypersensitivity to medication needed for procedure</td> <td><input type="checkbox"/> Trans Ischemic Attack (TIA) or stroke within past three months</td> <td><input type="checkbox"/> Obstructive Sleep Apnea – NOT treated with CPAP: Refer the patient for Sleep Apnea Treatment</td> </tr> <tr> <td><input type="checkbox"/> Oxygen-dependent pulmonary disease</td> <td></td> <td><input type="checkbox"/> None of the above</td> <td></td> </tr> </table>	<input type="checkbox"/> Active bacterial infection	<input type="checkbox"/> Active smoking/nicotine use: enroll patient in a smoking cessation program	<input type="checkbox"/> Active drug or alcohol abuse	Cardiovascular Disease (any of the following): acute coronary symptoms, uncompensated Congestive Heart Failure (CHF), uncontrolled arrhythmia, uncontrolled hypertension (greater than 180/110 mm Hg), severe valvular disease, percutaneous coronary intervention (PCI) within 1 month	<input type="checkbox"/> *Morbid Obesity (BMI greater than 40); refer for weight loss management	<input type="checkbox"/> Advanced Renal Disease (creatinine greater than 2)	<input type="checkbox"/> Coagulopathy or on anticoagulant therapy	<input type="checkbox"/> Primary pulmonary hypertension	<input type="checkbox"/> Anemia – Hemoglobin less than 11 (females 11, males 12)	<input type="checkbox"/> Diabetes – HbA1c greater than or equal to 8%	<input type="checkbox"/> End Stage Liver Disease	<input type="checkbox"/> Uncontrolled Seizure Disorder	<input type="checkbox"/> History of Malignant Hyperthermia/Heat stroke	<input type="checkbox"/> Known allergy or hypersensitivity to medication needed for procedure	<input type="checkbox"/> Trans Ischemic Attack (TIA) or stroke within past three months	<input type="checkbox"/> Obstructive Sleep Apnea – NOT treated with CPAP: Refer the patient for Sleep Apnea Treatment	<input type="checkbox"/> Oxygen-dependent pulmonary disease		<input type="checkbox"/> None of the above	
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<input type="checkbox"/> Oxygen-dependent pulmonary disease		<input type="checkbox"/> None of the above																			



## Authorization Request Form - Part 2 Cardiac Ablation & Cardiac Implanted Device (Pacemaker)

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**i** Please fill in each question option completely ○ → ●

### Patient Information

First name	Last name
Member ID	Date of birth (MM/DD/YYYY)

Fill out the following section if submitting for any of the following: **Atrial Flutter, Atrial Fibrillation**

#### Question 1

Does the patient have any of the following surgical risk factors? (additional information)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Active bacterial infection  | Active smoking/nicotine use:  | <input type="checkbox"/> Active drug or alcohol abuse   | Cardiovascular Disease (any of the following): acute coronary symptoms, uncompensated Congestive Heart Failure (CHF), uncontrolled arrhythmia, uncontrolled hypertension (greater than 180/110 mm Hg), severe valvular disease, percutaneous coronary intervention (PCI) within 1 month |
| <input type="checkbox"/> *Morbid Obesity (BMI greater than 40); refer for weight loss management | <input type="checkbox"/> enroll patient in a smoking cessation program                  | <input type="checkbox"/> Coagulopathy or on anticoagulant therapy   |   |
| <input type="checkbox"/> Primary pulmonary hypertension  | <input type="checkbox"/> Advanced Renal Disease (creatinine greater than 2)             | <input type="checkbox"/> Diabetes – HbA1c greater than or equal to 8%   |   |
| <input type="checkbox"/> End Stage Liver Disease   | <input type="checkbox"/> Anemia – Hemoglobin less than 11 (females 11, males 12)        | <input type="checkbox"/> History of Malignant Hyperthermia/Heat stroke  |   |
| <input type="checkbox"/> Known allergy or hypersensitivity to medication needed for procedure    | <input type="checkbox"/> Uncontrolled Seizure Disorder                                  | <input type="checkbox"/> Obstructive Sleep Apnea – NOT treated with CPAP: Refer the patient for Sleep Apnea Treatment | <input type="checkbox"/> None of the above  |
| <input type="checkbox"/> Oxygen-dependent pulmonary disease                                      | <input type="checkbox"/> Trans Ischemic Attack (TIA) or stroke within past three months |   |   |

Fill out the following section if submitting for any of the following: **Atrial Flutter**

#### Question 1

Does the patient have any of the following arrhythmias?

- Associated sinus node dysfunction       Symptomatic bradycardia  
 Atrioventricular (AV) node dysfunction       None of the above

#### Question 2

Is the patient a candidate for single- or dual-chamber pacing due to symptomatic low heart rates?

- Yes     No

Fill out the following section if submitting for any of the following: **Atrial Fibrillation**

#### Question 1

Which of the following findings were documented within the past three months?

- Persistent atrial fibrillation       Paroxysmal atrial fibrillation  
 Permanent atrial fibrillation       None of the above

#### Question 2

Does the patient have associated symptomatic bradycardia, sinus node dysfunction, or AV node dysfunction?

- Yes     No

#### Question 3

Is the patient a candidate for AV node ablation?

- Yes     No



## Authorization Request Form - Part 2 Atrioventricular Node Ablation

Complete and fax the clinical worksheet immediately following the authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

**i** Please fill in each question option completely  →

### Patient Information

First name	Last name
Member ID	Date of birth (MM/DD/YYYY)

Fill out the following section if submitting for any of the following: **Atrial Fibrillation**

<b>Question 1</b>	<p>Which of the following findings were documented within the past three months?</p> <p><input type="radio"/> Persistent atrial fibrillation    <input type="radio"/> Paroxysmal atrial fibrillation</p> <p><input type="radio"/> Permanent atrial fibrillation    <input type="radio"/> None of the above</p>				
<b>Question 2</b>	<p>Is the patient an unfavorable candidate for rhythm control, either by pharmaceutical or interventional means?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p>				
<b>Question 3</b>	<p>Has pharmacologic rate control been attempted?</p> <p><input type="radio"/> Yes, though unsuccessful due to rhythm refractoriness or patient intolerance    <input type="radio"/> No, pharmacologic rate control has not been attempted</p> <p><input type="radio"/> Yes, rate control was successful</p>				
<b>Question 4</b>	<p>Does the patient have a permanent pacemaker, or is a candidate for ventricular pacing?</p> <p><input type="radio"/> Yes    <input type="radio"/> No</p>				
<b>Question 5</b>	<p>Does the patient have any of the following surgical risk factors? (additional information)</p> <table style="width: 100%; border: none;"> <tr> <td style="vertical-align: top; width: 25%;"> <input type="checkbox"/> Active bacterial infection  <input type="checkbox"/> *Morbid Obesity (BMI greater than 40); refer for weight loss management  <input type="checkbox"/> Primary pulmonary hypertension  <input type="checkbox"/> End Stage Liver Disease  <input type="checkbox"/> Known allergy or hypersensitivity to medication needed for procedure  <input type="checkbox"/> Oxygen-dependent pulmonary disease         </td> <td style="vertical-align: top; width: 25%;">           Active smoking/nicotine use:  <input type="checkbox"/> enroll patient in a smoking cessation program  <input type="checkbox"/> Advanced Renal Disease (creatinine greater than 2)  <input type="checkbox"/> Anemia – Hemoglobin less than 11 (females 11, males 12)  <input type="checkbox"/> Uncontrolled Seizure Disorder  <input type="checkbox"/> Trans Ischemic Attack (TIA) or stroke within past three months         </td> <td style="vertical-align: top; width: 25%;"> <input type="checkbox"/> Active drug or alcohol abuse  <input type="checkbox"/> Coagulopathy or on anticoagulant therapy  <input type="checkbox"/> Diabetes – HbA1c greater than or equal to 8%  <input type="checkbox"/> History of Malignant Hyperthermia/Heat stroke  <input type="checkbox"/> Obstructive Sleep Apnea – NOT treated with CPAP: Refer the patient for Sleep Apnea Treatment         </td> <td style="vertical-align: top; width: 25%;">           Cardiovascular Disease (any of the following): acute coronary symptoms, uncompensated Congestive Heart Failure (CHF), uncontrolled arrhythmia, uncontrolled hypertension (greater than 180/110 mm Hg), severe valvular disease, percutaneous coronary intervention (PCI) within 1 month  <input type="checkbox"/> None of the above         </td> </tr> </table>	<input type="checkbox"/> Active bacterial infection <input type="checkbox"/> *Morbid Obesity (BMI greater than 40); refer for weight loss management <input type="checkbox"/> Primary pulmonary hypertension <input type="checkbox"/> End Stage Liver Disease <input type="checkbox"/> Known allergy or hypersensitivity to medication needed for procedure <input type="checkbox"/> Oxygen-dependent pulmonary disease	Active smoking/nicotine use: <input type="checkbox"/> enroll patient in a smoking cessation program <input type="checkbox"/> Advanced Renal Disease (creatinine greater than 2) <input type="checkbox"/> Anemia – Hemoglobin less than 11 (females 11, males 12) <input type="checkbox"/> Uncontrolled Seizure Disorder <input type="checkbox"/> Trans Ischemic Attack (TIA) or stroke within past three months	<input type="checkbox"/> Active drug or alcohol abuse <input type="checkbox"/> Coagulopathy or on anticoagulant therapy <input type="checkbox"/> Diabetes – HbA1c greater than or equal to 8% <input type="checkbox"/> History of Malignant Hyperthermia/Heat stroke <input type="checkbox"/> Obstructive Sleep Apnea – NOT treated with CPAP: Refer the patient for Sleep Apnea Treatment	Cardiovascular Disease (any of the following): acute coronary symptoms, uncompensated Congestive Heart Failure (CHF), uncontrolled arrhythmia, uncontrolled hypertension (greater than 180/110 mm Hg), severe valvular disease, percutaneous coronary intervention (PCI) within 1 month <input type="checkbox"/> None of the above
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