

**Alabama Medicaid Agency**  
**Oxygen Therapy**  
*Request for Prior Authorization and Prescription*

**Patient Information**

Patient Name \_\_\_\_\_ Patient Medicaid Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Diagnosis \_\_\_\_\_

**Prescription Information**

Date last seen by physician \_\_\_\_\_

Date oxygen prescribed \_\_\_\_\_  Initial  Renewal

Liters per minute \_\_\_\_\_ Hours per day \_\_\_\_\_

Method of delivery (nasal cannula, mask, etc.) \_\_\_\_\_

If portable oxygen prescribed, state purpose \_\_\_\_\_

Estimated length of time oxygen needed \_\_\_\_\_ (months)

Describe type, duration, and frequency of recipient's daily activities outside the home \_\_\_\_\_

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Equipment Prescribed

Stationary System

- Compressed Gas
- Oxygen Concentrator

Portable System

- Compressed Gas

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**Laboratory Results**

ABG (P02) result \_\_\_\_\_  Room Air  Oxygen  Awake  Asleep Date of test \_\_\_\_\_

Oxygen Saturation \_\_\_\_\_  Room Air  Oxygen  Awake  Asleep Date of test \_\_\_\_\_

***Must attach a copy of the ABG report or oxygen saturation readout. ABG not required for children.***

If ABG was not performed, please explain \_\_\_\_\_

If test not performed on room air, please explain \_\_\_\_\_

If ABG exceeds 59 mm Hg or if oxygen saturation exceeds 89 percent (94 percent for children three and under), physician must justify need for oxygen with more medical information.

For oxygen approved during activity, submit three oximetry studies from the same session: (1) testing at rest without oxygen; (2) testing during activity without oxygen; (3) testing during exercise with oxygen applied to demonstrate improvement of hypoxemia.

For nocturnal oxygen, provide download of overnight oximetry that shows documentation of the duration of desaturation below the specified value.

(Attach a separate letter if more space is needed to justify medical necessity)

**I certify that oxygen is medically necessary.**

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

(Stamped signatures are not acceptable)