Letter of Medical Necessity / Prescription
iNAP Sleep Therapy System – Treatment for Obstructive Sleep Apnea

Patient Information	
Patient Name	
Patient DOB	
Gender	☐ Male ☐Female

Physician Information	
Physician Name	
Physician NPI Number	
Physician Phone Number	
Physician Address	

I am writing on behalf of my patient, to document the medical necessity of iNAP®, a nonsurgical device indicated for home use in the treatment of obstructive sleep apnea (OSA). This letter provides information about the patient's medical history, clinical diagnosis and a statement certifying the necessity of this medical treatment.

Patient's History and Diagnosis

has been diagnosed by a Board-Certified Sleep Physician with Obstructive Sleep Apnea (OSA) (G47.33) who has recommended iNAP®, Intermittent Negative Airway Pressure Sleep Therapy (HCPCS E0600).

Other chronic conditions or co-morbidities _____

This patient is:	
☐	CPAP Intolerant, has rejected CPAP, or after trialing CPAP, is noncompliant(E0601)
☐	Has tried and cannot use an Oral Appliance (E0486)
☐	Has been impacted by the Philips CPAP recall and/or supply chain issues and has been unable to treat their obstructive sleep apnea.
☐ Other:	

Diagnosis codes	
☐	Obstructive Sleep Apnea (G47.33)
☐	Unspecified Sleep Apnea (G47.30)
☐	Snoring (R06.83)
☐	Nocturnal Bruxism (G47.63)
☐	Hypersomnia Unspecified (G47.10)

Product Description

iNAP is a prescription device manufactured by Somnics Health with the following indications for use: iNAP is a removable intraoral

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pressure gradient device, electrically powered and operates by reducing the pressure in the oral cavity (by way of tubing and a noninvasive oral interface) to create a continuous positive pressure gradient from the airway to the oral cavity that urges the soft palate and tongue forward. It is intended to be used while a patient is sleeping to treat obstructive sleep apnea. FDA Classification Device Class 2, FDA clearance 510 (k) submission K193460 (05/26/2020).

Prescription
The following device and accessories are medically necessary

Check if applicable	HCPCS Code	Description	Dispense QTY	Refill QTY	DME or DME Accessory
☐	E0600	iNAP console	1		DME
☐	A7001	Saliva container	1	1 Every 6 months	Accessory
☐	A7002	Tubing	1	1 Every 3 months	Accessory
☐	A7047	Oral interface	1	1 Every 3 months	Accessory
☐	A9900	Dry pads	92	1 Every day	Accessory

The above-referenced patient was diagnosed as indicated.
This document serves as a Prescription and Statement of Medical Necessity to treat their obstructive sleep apnea (OSA) to prevent the cardiac, neurological, and psychiatric consequences on untreated OSA.
I certify that I am the physician identified in the above section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge.
I certify that iNAP is indicated as a treatment and in my opinion, is reasonable and medically necessary regarding the standards of medical practice for this patient's condition.
In the absence of any diagnosed medical condition such as Central Sleep Apnea or congestive heart failure, or any other medical condition known to be contraindicated, I am prescribing the iNAP Sleep therapy system.

X _____

MD / DO / NP / PA-C

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