Beneficiary Full Name: _____ Sponsor's SSN: _____-_____-_____

Date of Birth: _____ Beneficiary State of Residence: _____

Dear Provider,

Please complete the letter of attestation below and return as indicated on the additional information request letter.

TRICARE Policy Manual Chapter 8, Section 5.4, Automated External Defibrillators (AEDs) authorizes coverage when coverage criteria are met. Coverage may be extended for either a wearable or non-wearable AED when a beneficiary meets the coverage criteria for both. However, because wearable and non-wearable AEDs serve the same purpose only one type (wearable OR non-wearable) may be cost-shared.

Please complete the appropriate section below based on the type of AED requested.

Wearable AED (HCPCS code K0606) – Section I
Non-Wearable AED (HCPCS code E0617) – Section II

Section I: Wearable AED

A wearable AED (HCPCS code K0606) may be covered when at least one of the following are documented:

- ☐ an episode of ventricular fibrillation or a sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia (not occurring during the first 48 hours after an acute myocardial infarction (MI)),
- ☐ a familial or inherited condition with a high risk of life-threatening ventricular tachyarrhythmia, such as long QT syndrome or hypertrophic cardiomyopathy,
- ☐ either a prior MI or dilated cardiomyopathy with a measured left ventricular ejection fraction less than or equal to 0.35, or
- ☐ a previously implanted defibrillator requires removal/explantation.

Section II: Non-Wearable AED

A non-wearable AED (HCPCS code E0617) may be covered when a previously implanted defibrillator requires removal/explantation or when an implanted AED is contraindicated and one of the following is documented.

- ☐ a previously implanted defibrillator requires removal/explantation,
- ☐ an episode of cardiac arrest due to ventricular fibrillation, not due to a transient or reversible cause,
- ☐ an episode of ventricular fibrillation or a sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia not associated with acute MI and not due to a transient or reversible cause,
- ☐ a familial or inherited condition with a high risk of life-threatening ventricular tachyarrhythmia, such as long QT syndrome or hypertrophic cardiomyopathy,
- ☐ coronary artery disease with a prior MI with a measured left ventricular ejection fraction less than or equal to 0.35 and inducible, sustained ventricular tachycardia or ventricular fibrillation during an electrophysiologic (EP) study. To meet this criterion:
  - ☐ the MI must have occurred more than four weeks prior to prescribing the external defibrillator; and
  - ☐ the EP test must have been performed more than four weeks after the qualifying MI.

(Continued next page)

☐ a prior MI and measured left ventricular ejection fraction less than or equal to 0.30, but only when the beneficiary:

- ☐ does not have cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm,
- ☐ has not had a coronary artery bypass graft or percutaneous transluminal coronary angioplasty within the past three months,
- ☐ has not had an enzyme-positive MI within the past month,
- ☐ does not have clinical symptoms or findings that would make them a candidate for coronary revascularization,
- ☐ does not have irreversible brain damage from preexisting cerebral disease, or
- ☐ does not have any disease, other than cardiac disease (for example, cancer, uremia, liver failure), associated with a likelihood of survival less than one year.

☐ ischemic dilated cardiomyopathy, documented prior MI, New York Heart Association (NYHA) Class II and III heart failure, and measured left ventricular ejection fraction less than or equal to 35 percent,

☐ non-ischemic dilated cardiomyopathy greater than three months, NYHA Class II and III heart failure, and measured left ventricular ejection fraction less than or equal to 35 percent, or

☐ any of the previous criteria and NYHA Class IV heart failure.

I attest the information provided is true and accurate to the best of my knowledge. I understand Health Net Federal Services, LLC or designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Additional information: _____

Physician's printed name and title:_____

TIN: _____

Signature: _____ Date: _____

This document may contain information covered under the Privacy Act (5 USC §552a) and/or the Health Insurance Portability and Accountability Act (P.L.104-191) and its various implementing regulations and must be protected in accordance with those provisions. If you have received this correspondence in error, please notify 1-844-866-WEST (9378) at once and destroy the documents and any copies you have made.

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