6 Steps
to myAIRVO 2 prescription

1.
Reason for prescription

The diagnosis or symptoms for which myAIRVO 2 is expected to benefit should be included in the prescription, as well as the required duration of therapy. This could be:

→ A specified number of months
→ Until condition resolves
→ Permanent

2.
Prescribed equipment

The equipment should be specified by manufacturer and model.

→ Device (e.g. F&P myAIRVO 2)
→ Interface type and size if applicable (e.g. F&P Optiflow+ Medium)

3.
Usage

Provide options for physicians for when they want their patients to use myAIRVO 2 high flow therapy.
This could be:

→ During the day
→ During the night
→ A minimum number of hours per day

Therapy settings

4.
Target total flow

The sum of the flow rates of air and any supplemental oxygen, in liters per minute (L/min). The total target flow should meet or surpass the patient's inspiratory demand, and may be prescribed as a specific flow rate or a range.

Note: myAIRVO 2 provides flow from 10 L/min to 60 L/min in Default mode, and from 2 L/min – 25 L/min in Junior mode.

5.
Temperature

May be prescribed, or left to patient preference.

→ myAIRVO 2 can be set at 31 °C, 34 °C or 37 °C.

Note: : For tracheostomy application 37 °C is most suitable. Junior mode is automatically set at 34 °C.

6.
Supplemental Oxygen

Supplemental oxygen may or may not be required. If oxygen is required, it can be prescribed in one of the following ways:

→ Specific flow rate (e.g. 10 L/min of oxygen). This should be lower than the target total flow set on myAIRVO 2.
→ Maintain an oxygen saturation (e.g. SaO_2 > 88 %)
→ Maintain a Fraction of inspired oxygen (e.g. FiO_2 > 30 %). myAIRVO 2 is able to deliver up to 100% FiO_2

Note: An increase in supplemental oxygen will not alter the target total flow. Oxygen should not be used while smoking or in the presence of an open flame.

This guideline describes the factors for physicians to be aware of when preparing the prescription for myAIRVO 2. It is not intended to direct the physician or imply this will provide suitable treatment. The physician is responsible for what is prescribed. The myAIRVO 2 instructions for use should also be consulted.

F&P myAIRVO™ 2

Fisher & Paykel HEALTHCARE

MYAIRVO™ REFERRAL FORM

Date: _____ / ____ / _____

PATIENT INFORMATION			
First Name:	Last Name:		DOB:
Patient Gender:	☐ Male	☐ Female	☐ Unknown
Primary Diagnosis:			
Reason for Prescription:			

myAIRVO™ SETTINGS		
Equipment:	F&P myAIRVO with	☐ OPT942E Small Optiflow+ Nasal Cannula ☐ OPT944E Medium Optiflow+ Nasal Cannula ☐ OPT946E Large Optiflow+ Nasal Cannula ☐ OPT970E Optiflow+ Tracheostomy Interface
Therapy to be used for	☐ During the day for a minimum of ____ hours ☐ During the night for a minimum of ____ hours ☐ Continuous day and night	
Flow: (Range: 2 - 60lpm)		
Temperature:	☐ 31 ☐ 34 ☐ 37	☐ Titrate to comfort
FiO2 Goal:		
SpO2 Goal:		

PHYSICIAN	
Name:	
Signature:	
Registration Number:	

Disclaimer

The myAIRVO Referral Form is for guidance purposes only, and is not intended for actual use