Advanced Care Solutions

INTERMITTENT CATHETERIZATION PRESCRIPTION FORM

Complete Medical Supplies

Patient Name: _____ **DOB:** _____
Address: _____ **Phone #:** _____
City: _____ **State** _____ **Zip Code:** _____
Insurance Name: _____ **Insurance Id#:** _____

DIAGNOSIS: **PRIMARY:** ICD-10 Code: _____ Code Description: _____
SECONDARY: ICD-10 Code: _____ Code Description: _____

START DATE: ____/____/_____ **REFILLS ALLOWED:** (____) 3 MONTHS (____) 6 MONTHS (_____) 12 MONTHS

SUPPLIES ORDERED & TREATMENT (Select ALL that apply - based on Medicare allowable):

SUPPLY & QUANTITY per month (select):

(____) Intermittent Urinary STRAIGHT Catheter / A4351 - Size/FR: _____ Qty:_____ (200 max per month)

(____) Intermittent Urinary COUDE TIP* Catheter / A4352 - Size/FR: _____ Qty:_____ (200 max per month)

(____) Intermittent Urinary STERILE* Catheter Kit / A4353 - Size/FR: _____ Qty:_____ (200 max per month)

(____) Other/ Specify:_____ - Size/FR: _____ Qty:_____

(____) TUBE of LUBRICANT/ A4332 (2 max per month) -OR- (____) LUBRICANT PACKS/A4332 (200 max per month)

***Additional Medical Documentation REQUIRED for STERILE Catheter System or COUDE Catheter (Select ALL that apply):**

(____) Patient is Immunosuppressed (select below):
- ___on regimen of immunosuppressed drugs post-transplant
- ___ On cancer Chemotherapy
- ___ HIV positive
- ___ Patient has a drug induced state such as oral corticosteroid use

(___) Patient has radiologically documented vesico-ureteral reflux while on program of intermittent catheterization
(___) Patient is a spinal cord injured female with neurogenic who is pregnant
(___) Patient has had distinct, recurrent UTIs: Twice within the past 12 months and each with cultures greater than 10,000 colonies -AND- concurrent presence of one or more of below signs, symptoms or laboratory findings (select below):
- ___ Fever (oral temperature greater than 100.4 F)
- ___ Systematic leukocytes
- ___ Change in urinary urgency, frequency or incontinence
- ___ Appearance of new or increase in autonomic dyreflexia (sweating, gradycardia, blood pressure elevation)
- ___ Physical signs of prostatitis, epididymitis, orchitis
- ___ Increased muscle spasms
- ___ Pyuria (greater than 5 white blood cells/WBCs per high powered field)

Latex ALLERGY - Documented in patient medical record: (_____) yes

Medical Justification for COUDE Catheter in females:_____

PHYSICIAN ATTESTATION: I certify with my signature that I am the physician named below. The information contained on this Written Order is true and complete to the best of my knowledge. This patient was evaluated by me and treated for the condition as stated above. The patient's medical record accurately contains documentation to support medical need and utilization of the supplies prescribed by me. **This order for supplies is reasonable and necessary for the diagnosis and treatment of the patient's illness**. The patient and or caregiver has been trained on the proper use of the supplies and is capable of following these instructions. A copy of this signed order will be maintained on file as part of the patient's medical record and made available to Medicare or other Insurance for post payment review or audits.

PHYSICIAN NAME (PRINT): _____ **NPI #:** _____**PHONE #:** _____

PHYSICIAN SIGNATURE: _____ **DATE**_____

ADVANCED CARE SOLUTIONS - PHONE: (877) 748-1977; FAX: 877-748-1985

COMPLETE MEDICAL SUPPLIES - PHONE: (866) 748-5151; FAX: 866-634-8166