



OSTOMY PRESCRIPTION FORM



PATIENT NAME: _____	DOB: _____
ORDER DATE: _____	REFILLS: ☐ LIFETIME () OTHER: ____ mo.

PHYSICIAN INSTRUCTIONS: All items marked (X) below are ordered as written. Cross out any item you are not prescribing for this patient. Items not struck through are ordered as listed.

DISPENSING BASIS: Unless a different interval is stated on the line, all quantities reflect a 30-DAY (ONE MONTH) SUPPLY. May be dispensed in 1-, 2-, or 3-month increments where plan limits and refill requirements allow; not to exceed a 3-month supply at one time.

STOMA COUNT (marked by supplier at intake): ☐ ONE STOMA — use Column A ☐ TWO STOMAS — use Column B

Two stomas must be documented in the medical record with corresponding ICD-10 diagnosis codes. Continued need and continued use of all items are verified with the patient prior to each shipment; only items confirmed as needed are dispensed.

	ITEM ORDERED	A. ONE STOMA	B. TWO STOMAS
POUCHES / BAGS			
(X)	Ostomy Drainable Pouch	20 ea	40 ea
(X)	Ostomy Closed End Pouch	60 ea	120 ea
() PATIENT ALTERNATES POUCH TYPE BY MONTH — dispense EITHER drainable OR closed end in a given month, not both.			
WAFERS / FLANGES			
(X)	Ostomy Wafer / Flange	20 ea	40 ea
ACCESSORIES			
(X)	Skin Barrier Sheet, 4x4 or equivalent	20 ea	40 ea
(X)	Skin Barrier Sheet, extended wear, 4x4 or equivalent	20 ea	40 ea
(X)	Skin Barrier Sheet, 6x6 or equivalent	20 ea	40 ea
(X)	Barrier Strips / Extenders	20 ea	40 ea
(X)	Skin Prep / Barrier Wipes	25 ea	50 ea
(X)	Skin Prep / Barrier Spray or Liquid	1 btl	2 btl
(X)	Adhesive Remover Wipes	50 ea	100 ea
(X)	Adhesive Remover Spray or Liquid	1 btl	2 btl
(X)	Ostomy Paste	2 oz	4 oz
(X)	Stoma Seal or Plug	31 ea	62 ea
(X)	Ostomy Barrier Ring	31 ea	62 ea
(X)	Ostomy Powder	1 oz	2 oz
(X)	Ostomy Deodorant — bottle	16 oz	32 oz
(X)	Ostomy Deodorant — packets	13 ea	26 ea
(X)	Appliance Cleaner	16 oz	32 oz
(X)	Ostomy Belt	1 ea	2 ea
(X)	Ostomy Vent / Pouch Filter	60 ea	120 ea
(X)	Tape, any size	40 units	80 units
UROSTOMY PATIENTS ONLY — CROSS OUT THIS SECTION IF NOT APPLICABLE			
(X)	Urinary Drainage Bag (bedside)	2 ea	4 ea
(X)	Urinary Leg Bag	2 ea	4 ea
(X)	Urinary Drainage Bottle	2 ea / 6 mo	4 ea / 6 mo
OTHER / ADDITIONAL ITEMS			
Other (product, REF# if available, and quantity — e.g., stoma sleeves, gauze): _____			
Additional quantity needed for coverage: _____			
Any quantity exceeding the standard allowable requires additional supporting medical records, and prior authorization plus supporting records where required by the patient's health plan. Please submit with the signed order.			

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 documented in the patient's medical record. The patient's medical record accurately contains documentation to support the 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: _____ **NPI #:** _____ **PHONE #:** _____
PHYSICIAN SIGNATURE: _____

REFERRAL SUBMISSION — fax or email this form with: (1) Patient Face Sheet with current demographics and insurance; (2) Medical Record from the last 30 days, with diagnosis codes, confirming need for supplies (e.g., Z93.2, Z93.3, Z93.6 or similar).

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