Home Phototherapy Prescription Form

Home Phototherapy Distributor

Fax to: 214-414-2533 ▪ Email to: sales@dermitech.com

Prescriber: This form may be used as the Prescription and Letter of Medical Necessity to order home phototherapy equipment. Please call 214-377-8144 for assistance.

Patient

Name ____________________ DOB ____ / ____ / ________

Address ____________________ Phone ____________

City ____________ State ______ Zip ________ Alt Phone ____________

Prescriber

Provider Name ____________________

Provider NPI ____________________

Clinic Name ____________________

Clinic Phone ____________________

Prescribed Device

	HCPCS	Description
☐	E0691	Wand hand-held device for scalp or a few spots.
☐	E0691 UPGRADE	Small Panel for localized areas including face, hands, feet, elbows.
☐	E0694	Cabinet six feet tall for full-body treatment.
☐	______	Other: ____________

Device Features

Lamp Type: NB-UVB (default) ☐ Other ______

Controller: Timer (default) ☐ Other ________

Treatments Limiting: Disabled (default)

Require refill code after:
- ☐ 75-100 treatments
- ☐ 100-150 treatments
- ☐ Other __________

Diagnosis & Statement of Medical Necessity

	ICD-10	Description
☐	L40. ___	Psoriasis
☐	L80	Vitiligo
☐	___ . ___	____________

Est. Length of Need: ____ Months ☐ Lifetime

Body Area Affected (Check all that apply)
- ☐ 3% - 10% (Moderate) ☐ Hands (2%)
- ☐ > 10% (Severe) ☐ Feet (2%)
- ☐ Other: ______% ☐ Scalp (9%)

List Previous Treatments: Was it Effective?
- ____________________ ☐ Yes ☐ No
- ____________________ ☐ Yes ☐ No
- ____________________ ☐ Yes ☐ No

Date Treatment Began: ____ / ____ / ______

Has patient been treated with UV Light Therapy in the past? (In the office or home) ☐ Yes ☐ No

If yes, did the patient benefit from it? ☐ Yes ☐ No

Is the patient and/or caregiver reliable, motivated and able to adhere to instructions? ☐ Yes ☐ No

Reason for Home Use: (please check all that apply)
- ☐ Therapy is Considered Long-Term
- ☐ Distance and Travel Time to Office
- ☐ Infection Risk of Regular Clinic Treatments
- ☐ Unable to Take Time Away from Work / School
- ☐ Other: ____________________

Signature

I certify that I am the provider identified on this form. I have reviewed this Prescription and Written Order. Any statement on my letterhead attached hereto has also been reviewed and signed by me. I certify that this patient and/or caregiver is capable and will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the product listed, and the provider notes and other supporting documentation will be provided upon request. I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Provider Signature (Required) ____________________ **Date** ____________

Home Phototherapy Dosing Order
- Narrowband UVB -

Please fax to 214-414-2533 or e-mail to sales@dermitech.com

Prescriber: This form may be used to specify a home phototherapy treatment regimen. This information will be used by Dermitech to instruct and guide your patient (if selected). Please call 214-377-8144 for assistance.

Patient

Patient Name: ____ DOB: ____/____/_________

Diagnosis: Code (ICD-10) __________ Description ______________________________

Select a Treatment Regimen

☐ **Dermitech to provide training to the patient using the example protocol below**

Select Skin Type	Starting Dose (mJ/cm²)	Select Dose Increases	Treatment Frequency
❐ I	200	❐ 10% ❐ 15%	3 times/week
❐ II	300		
❐ III	400		
❐ IV	500		
❐ V	700		
❐ VI	800		

☐ **Vitiligo: Dermitech to provide training to the patient using the example protocol below**

Vitiligo Protocol		
Starting Dose	**Dose Increases**	**Treatment Frequency**
200mJ/cm²	The greater of 50mJ or 10%	3X/week

☐ **Dermitech to provide training to the patient using the custom regimen below**

Skin Type (I-VI)	Starting Dose (mJ/cm² or mm:ss)	Dose Increases (mJ/cm² or % or seconds)	Treatment Frequency

☞ Unless instructed otherwise, Dermitech's written treatment instructions will be provided and reviewed with the patient. To request a copy, please call 214-377-8144.

☐ **Do not provide training or treatment instructions to the patient**
My staff will provide training and guidance to the patient.

Signature

I certify that I am the patient's physician or authorized by the patient's physician to provide home treatment information for the patient above. Unless instructed otherwise, the information above will be used by Dermitech to advise the patient in managing home treatments. A copy of this order will be retained as part of the patient's medical record.

Signature ____________________________________

Name (please print) ____________________________________ **Date** __________________