

Prescription & Written Order For Home Phototherapy



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 _____
 Practice _____
 Phone # _____
 NPI # _____

Prescribed Device

HCPCS	Description
<input type="checkbox"/> E0691	<u>Wand</u> hand-held device for scalp or a few spots.
<input type="checkbox"/> E0691 UPGRADE	<u>Small Panel</u> for localized areas including face, hands, feet, elbows.
<input type="checkbox"/> E0694	<u>Cabinet</u> six feet tall for full-body treatment.
<input type="checkbox"/> _____	Other: _____

Device Features

Lamp Type: NB-UVB (default) Other _____

Controller: Timer (default) Other _____

Treatment Limiting: Disabled (default) Require refill code after:
 75-100 treatments
 100-150 treatments

Diagnosis & Statement of Medical Necessity

ICD-10	Description
<input type="checkbox"/> L40. ____	Psoriasis
<input type="checkbox"/> L80	Vitiligo
<input type="checkbox"/> ____.	_____

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 -



Home Phototherapy
Distributor

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 _____

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

Select Skin Type	Starting Dose (mJ/cm ²)	Select Dose Increases	Treatment Frequency
<input type="checkbox"/> I	200	<input type="checkbox"/> 10% <input type="checkbox"/> 15%	3 times/week
<input type="checkbox"/> II	300		
<input type="checkbox"/> III	400		
<input type="checkbox"/> IV	500		
<input type="checkbox"/> V	700		
<input type="checkbox"/> VI	800		

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

Vitiligo Protocol		
Starting Dose	Dose Increases	Treatment Frequency
200mJ/cm ²	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/cm ² or mm:ss)	Dose Increases (mJ/cm ² 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 _____