V.A.C.® Therapy Insurance Authorization Form (v8.0)

Please fax this form to 3M-KCI at: **1-888-245-2295**
3M-KCI Customer Service: **1-800-275-4524**

1 Patient and insurance information (Important: please submit demographic and/or insurance sheet)

Patient name (print): Last: _____ First: _____ MI: ____ Patient DOB: _____ /_____ /_____

(skip completing patient's home address if demographic/insurance sheet submitted) Patient email: _____

Home address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____ Phone: _____

Emergency contact (if available): _____ Phone: _____

Primary insurance: _____ Policy#: _____ Secondary insurance: _____ Policy#: _____

2 Prescriber information (Complete in full or fax written prescription to include the following)

I prescribe 3M-KCI V.A.C.® Therapy for the following wound type(s):

☐ Pressure ulcer(s) ☐ Diabetic ulcer(s) ☐ Venous ulcer(s) ☐ Arterial ulcer ☐ Surgically created ☐ Other: _____

I prescribe 3M-KCI V.A.C.® Therapy for: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ Other (weeks): _____
and up to 15 V.A.C.® Therapy dressings per wound and up to 10 V.A.C.® Therapy canisters per month.

Provide narrative description specifying wound etiology and including anatomical location(s): _____

Order date of HOMECARE 3M-KCI V.A.C.® Therapy: _____ /_____ /_____

Goal at the completion of 3M-KCI V.A.C.® Therapy: ☐ Assist in granulation tissue formation ☐ Flap ☐ Graft ☐ Delayed primary closure (tertiary)

Treating prescriber name (print): Last: _____ First: _____ MI: ____

Address: _____

City: _____ State: _____ Zip code: _____

Prescriber phone: _____ Fax: _____ Email: _____ NPI: _____

☐ Request an electronically signed prescription from prescriber (please provide prescriber's email): _____

Prescriber only to sign and date. Original prescriber signature required. Stamps and photocopies strictly prohibited.

Prescriber Signature: _____ Date: _____ /_____ /_____

By signing and dating, I attest that I am prescribing the 3M-KCI V.A.C.® Negative Pressure Wound Therapy System **(do not substitute)** as medically necessary, and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information and other instructions for use included with the 3M-KCI V.A.C.® Therapy product, as well as the V.A.C.® Therapy Clinical Guidelines. I also understand the V.A.C.® Therapy System contraindications.

3 Supplies for delivery (please check the V.A.C.® Dressing(s) requested)

Dermatac™ Drape with V.A.C.® GRANUFOAM™ Dressing Kit	☐ Small	☐ Medium	☐ Large	**V.A.C.® WHITEFOAM™ Dressing**	☐ Small ☐ Large
V.A.C.® SIMPLACE™ (EX Dressing)	☐ Small	☐ Medium		**V.A.C.® GRANUFOAM™ Bridge Dressing**	☐
V.A.C.® SIMPLACE™ Dressing	☐ Small	☐ Medium		**V.A.C.® GRANUFOAM™ Bridge XG Dressing**	☐
V.A.C.® GRANUFOAM™ Dressing	☐ Small	☐ Medium	☐ Large	Other dressing: _____	Qty: _____

4 Post Acute Clinical Provider information (Provider administrating dressing changes please complete in full)

Requestor facility information: Requestor Name: _____ Title: _____

Requestor facility name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

☐ Check here to be emailed a link to status information on this order. Email for status link: _____

Delivery Location: ☐ Home ☐ Facility/RM#: _____ ☐ Other: _____

Delivery Address: _____ City: _____ State: _____ Zip: _____

Need by date: _____ /_____ /_____ Need by time: _____ V.A.C.® Therapy System will be used in what type of facility:

☐ Private residence ☐ WCC ☐ SNF ☐ LTAC/Rehab ☐ Assisted living ☐ Other: _____

Post Acute Clinical Provider administering dressing changes: Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient name: _____ Patient DOB: _____ /_____ /_____ Completed by: _____

5a Clinical information by wound type

1. Was NPWT initiated in an inpatient facility? ☐ Yes ☐ No Date initiated: _____ /_____ /_____
   OR has the patient been on NPWT anytime during the last 60 days? ☐ Yes ☐ No Facility name: _____
2. Is the patient's nutritional status compromised? ☐ Yes ☐ No Facility city & state: _____
   If Yes, check the action taken: ☐ Protein supplements ☐ Enteral/NG feeding ☐ TPN ☐ Vitamin therapy ☐ Special diet
3. Indicate other therapies that have been previously tried and/or failed to maintain a moist wound environment:
   ☐ Saline gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid ☐ Absorptive ☐ None ☐ Other: _____
4. If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to applying V.A.C.® Therapy?
   ☐ Presence of co-morbidities ☐ High risk of infections ☐ Need for accelerated granulation tissue ☐ Prior history of delayed wound healing
   ☐ Other (please describe): _____
5. Which of the following co-morbidities apply? ☐ Diabetes ☐ Immobility ☐ Immunocompromised ☐ ESRD
   ☐ PVD ☐ PAD ☐ Obesity ☐ Smoking ☐ Depression ☐ N/A
6. If above diabetes box checked, is the patient on a comprehensive diabetic management program? ☐ Yes ☐ No ☐ N/A
7. Is Osteomyelitis present in wound? ☐ Yes ☐ No If yes, please indicate the following:
   ☐ Antibiotic (list name): _____ ☐ IV Antibiotics (list name): _____ ☐ Hyperbaric Oxygen
   Is the above treatment administered to the patient with the intention to completely resolve the underlying bone infection? ☐ Yes ☐ No
8. Please provide a short narrative of possible consequences if V.A.C.® Therapy is not used. (Please include/attach any clinical data such as H&P, OP report, and other medical documentation supporting treatments tried and describing factors impacting wound healing):
   _____

5b Patient's primary wound type (Please select one)

☐ **PRESSURE ULCER** ☐ Stage III ☐ Stage IV
1. Is the patient being turned/positioned? ☐ Yes ☐ No
2. Has a group 2 or 3 surface been used for ulcer located on the posterior trunk or pelvis? ☐ Yes ☐ No
3. Are moisture and/or incontinence being managed? ☐ Yes ☐ No
4. Is pressure ulcer greater than 30 days? ☐ Yes ☐ No

☐ **DIABETIC ULCER/NEUROPATHIC ULCER**
1. Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? ☐ Yes ☐ No

☐ **VENOUS STASIS ULCER/VENOUS INSUFFICIENCY**
1. Are compression bandages and/or garments being consistently applied? ☐ Yes ☐ No
2. Is elevation/ambulation being encouraged? ☐ Yes ☐ No

☐ **ARTERIAL ULCER/ARTERIAL INSUFFICIENCY**
1. Is pressure over the wound being relieved? ☐ Yes ☐ No

☐ **SURGICAL**
1. Was the wound surgically created and not represented by descriptions above? ☐ Yes ☐ No
2. Description of the surgical procedure: _____
   _____
3. Date of surgical procedure involving wound: _____ /_____ /_____

☐ **OTHER WOUND TYPE (Describe):** _____

Please complete if applicable:
Is wound a direct result of an accident? ☐ Yes ☐ No
If Yes, complete the following:
Date of accident: _____ /_____ /_____
Accident type: ☐ Auto ☐ Employment ☐ Trauma

5c Wound(s) description

Wound #1 type: _____ Age in months: _____
Wound location: _____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Was debridement attempted in the last 10 days? ☐ Yes ☐ No
If yes, debridement date: _____ /_____ /_____ Type: _____
Are serial debridements required? ☐ Yes ☐ No
Measurement date: _____ /_____ /_____
Length: _____ cm Width: _____ cm Depth: _____ cm
Appearance of wound bed and color: _____
Exudate (Amount and color): _____
Is the wound full thickness? ☐ Yes ☐ No
Is muscle, tendon or bone exposed? ☐ Yes ☐ No
Is there undermining? ☐ Yes ☐ No
Location #1: _____ cm, from _____ to _____ o'clock
Location #2: _____ cm, from _____ to _____ o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1: _____ cm, from _____ to _____ o'clock
Location #2: _____ cm, from _____ to _____ o'clock

Wound #2 type: _____ Age in months: _____
Wound location: _____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Was debridement attempted in the last 10 days? ☐ Yes ☐ No
If yes, debridement date: _____ /_____ /_____ Type: _____
Are serial debridements required? ☐ Yes ☐ No
Measurement date: _____ /_____ /_____
Length: _____ cm Width: _____ cm Depth: _____ cm
Appearance of wound bed and color: _____
Exudate (Amount and color): _____
Is the wound full thickness? ☐ Yes ☐ No
Is muscle, tendon or bone exposed? ☐ Yes ☐ No
Is there undermining? ☐ Yes ☐ No
Location #1: _____ cm, from _____ to _____ o'clock
Location #2: _____ cm, from _____ to _____ o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1: _____ cm, from _____ to _____ o'clock
Location #2: _____ cm, from _____ to _____ o'clock