V.A.C.® Therapy Insurance Authorization Form (v7.0)

KCI Customer Service: 1-800-275-4524

Please fax this form to KCI at **1-888-245-2295**

1 Patient 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: ____ST: ____________Zip Code: ______________Phone #: ____________________________

Emergency Contact (if available): ____Phone #: ___________________________

Primary Insurance _________________________Policy#___________________2nd Ins. ________________________Policy#__________________

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

I prescribe 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 ____________________________________

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

I prescribe 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.

Order date of HOMECARE V.A.C.® Therapy: _____/_____/______

Goal at the completion of 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: ____________________________ST: ______Zip: _________

Prescriber Phone: ____________________ Fax:_____________________ Email: ______________________________ NPI: _____________________

☐ **Request an electronically signed prescription from Prescriber** *(please provide Prescriber's email address)*

Prescriber Only to Complete Original Signature Required. No Stamps

Prescriber Signature: ____Date: ___/___/_____

By signing and dating, I attest that I am prescribing the 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 V.A.C.® Therapy product, as well as the KCI V.A.C.® Therapy Clinical Guidelines. I also understand the KCI V.A.C.® Therapy System contraindications.

3 Supplies for Delivery <u>Please check the V.A.C.® Dressing(s) requested</u>

V.A.C.® SIMPLACE™ (EX Dressing) ____ Small ____ Medium

V.A.C.® SIMPLACE™ Dressing ____ Small ____ Medium

V.A.C.® GRANUFOAM™ Dressing ____ Small ____ Medium ____ Large

V.A.C. WHITEFOAM™ Dressing ____ Small ____ Large

V.A.C.® GRANUFOAM™ Bridge Dressing ____

V.A.C.® GRANUFOAM™ Bridge XG Dressing ____

Other Dressing: ____

4 Requestor & Post-Acute Clinical Provider Information (Please complete in full)

<u>Requestor Facility Information</u> Requestor Name: _____________________________________Title: ___________________________

Requestor Facility Name: ____Phone: ______________Fax:___________

Address:____ City:______________________________State:______Zip:______

☐ Check here to be emailed a link to status information on this order Email Address for Status link: _____________________________________

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

Delivery Address: ____City:__________________________State:______Zip:__________

Need By Date: ______/________/________ Need By Time: ______:_______

KCI 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 ____Ph.______________

Address: ____City:_____________________________State:______Zip:__________

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Patient Name: ______________________ D.O.B.:____/____/_____ 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, St: ______________________
   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

☐ **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 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
Has debridement been attempted in the last 10 days? ☐ Yes ☐ No
If Yes, debridement date: _____/______/______
Debridement 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, at _________o'clock
Location #2: __________cm, at _________o'clock

Wound #2 Type: ______________________Age in Months: ________
Wound Location: ______________________
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Has debridement been attempted in the last 10 days? ☐ Yes ☐ No
If Yes, debridement date: ____/______/______
Debridement 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, at __________o'clock
Location #2: __________cm, at __________o'clock

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