VasoCARE™ LLC
Tomorrow's Technology for Today's Medical Needs

PNEUMATIC COMPRESSION DEVICE (PCD)
LYMPHEDEMA or CVI with Venous Ulcer
Prescription/Pre-Authorization Form

Place an Order:
orders@vasocare.com
Fax Us: 866-455-5150
Call Us: 225-924-0444

REQUIRED: Patient Demographics/Face Sheet & Copy of Insurance Card (front/back)

Physician's Name:	Contact Name:	Phone: / Fax:	Email:

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth (mm/dd/yy):	Medicare ID (If applicable):
Address:		**City:**	**State / ZIP:**
Patient Cell Phone (to schedule follow up visits):		**Location(s) of Lymphedema/Edema:**	

PUMP SELECTION

❒ **Basic Pump E0651**

❒ **Advanced Pump E0652**

Note: E0652 is allowed only if E0651 fails to improve clinical conditions.

MUST COMPLETE ALL SECTIONS

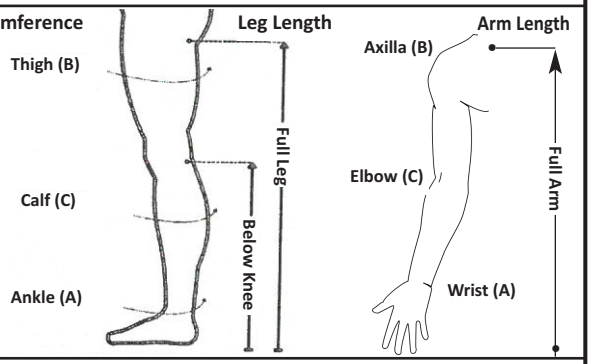
Measurements taken by staff nurse confirming persistence of lymphedema. (FOR SIZING of PCD sleeves)

❒ **Full Leg Sleeve (Thigh High)**

❒ **Full Arm Sleeve (Show the Length)**

Circumference	Left	Right
Thigh / Axilla (B)		
Calf / Elbow (C)		
Ankle / Wrist (A)		
Leg/Arm Length		

Please take measurements in cm.



ALL SECTIONS BELOW MUST BE COMPLETED BY A HEALTHCARE PROVIDER (MD, DO, PA,DPM, NP)

SECTION A: DIAGNOSIS INFORMATION — ***SELECT ALL THAT APPLY***

Lymphedema Stage:
- ❒ **I (Mild)**
- ❒ **II (Moderate)**
- ❒ **III (Severe)**

Diagnosis:
- ❒ **189.0 Secondary Lymphedema due to: _____ (Insert Etiology)**
- ❒ **197.2 Secondary Lymphedema Post-Mastectomy**
- ❒ **Q82.0 Primary Lymphedema (congenital/hereditary) including Lymphedema Tarda**
- ❒ **187.2 CVI with 6 months non-healing VLU(s) (L97.929 (Left) / L97.919 (Right)**

SECTION B: MEDICAL NECESSITY & COVERAGE CRITERIA DETAILS — **** ALL QUESTIONS MUST BE ANSWERED****

1. ❒ **Yes** ❒ **No** Has the patient tried & failed home treatments (adequate compression garments/exercise/elevation/wound dressing; as appropriate) for at least 4-weeks (or 6 months for VLUs) and significant symptoms remain, or with no significant improvement?
2. ❒ **Yes** ❒ **No** Have measurements been documented in the patients MR that confirm the persistence of Lymphedema?
3. ❒ **Yes** ❒ **No** Is the patient *CURRENTLY* experiencing any related complications/impairments/persisting symptoms (Select all that apply):
   ❒ *Hyperkeratosis* ❒ *Hyperpigmentation* ❒ *Cellulitis* ❒ *Papillomatosis (warts/nodules/papules)*
   ❒ *Lymphorrhea* ❒ *Skin Breakdown* ❒ *Deformity of Elephantiasis* ❒ *Other symptoms: _____*
4. Date of last face-to-face encounter with prescriber (mm/dd/yy): ____/____/____ ****Medicare requires a visit within the past 6 months****

RX: PNEUMATIC COMPRESSION DEVICE & GARMENTS

DEVICE & GARMENT SELECTION

❒ **E0651** (Basic)

❒ **E0652** (Advanced with calibrated, gradient pressure)

❒ **FULL LEG (E0667)** ❒ **Left** ❒ **Right**

❒ **FULL ARM (E0668)** ❒ **Left** ❒ **Right**

TREATMENT PROTOCOL

Duration per Leg	Daily Frequency	Pressure (mmHg)	Length of Need (choose one)
❒ 1 hr.	❒ 1x	❒ 40 (low)	❒ Lifetime
❒ 2 hrs.	❒ 2x.	❒ 50 (Med)	or
❒ Other: _____	❒ Other: _____	❒ 60 (High)	❒ Other: _____
		❒ Other: _____	

PRESCRIBER'S ORDER & ATTESTATION

I am the treating physician or practitioner for the above-named patient. I have examined the patient, maintained oversight of their condition throughout treatment, and have determined that the patient has a medical necessity for a pneumatic compression device. The patient has no contraindications that would prohibit use of a pneumatic compression device. The patent's medical record contains documentation showing the patient meets coverage criteria for a pneumatic compression device in accordance with applicable Medicare and other third-party payer coverage policies as indicated above. I will make such medical records available to YOU and third-party payer(s) upon request.

PRESCRIBER NAME:	PRESCRIBER SIGNATURE:	NPI:	DATE: