Prescription/Rx for Patients Suffering with Clinical Issues Due to Arterial Insufficiency

Physician's Name: _____ Phone: _____ Fax:_____ Contact: _____

Patient's Full Name (First, Middle Initial, Last) _____ Patient's Phone #: _____

Indications for E0675, a rapid high-pressure pneumatic device

□ Claudication Limb Pain - Right leg I70.211 or Left Leg I70.212
□ Tissue Loss – I96
□ Rest Pain or Ischemia Night Pain – I70.22
□ Diabetic Foot Ulcer – (Type 2 – E11.621) or (Type 1 – E10.621)
□ Adjunct Therapy for Ischemic Disease – I99.8
□ Angioplasty/Stent Failure – T82.856A
□ Graft Failure – T82.3
□ Small Vessel Disease – I67.82
□ Limb Salvage – L97.51

Symptoms: _____

Prior treatments tried/failed: _____

_____

_____

Recommended Use: 1 hour; 1-3 times daily

Apply to: ☐ Bilateral ☐ Right Leg ☐ Left Leg

Bio Arterial device with Limb Sleeves

Sizing Chart in Inches (Circumference)

∞ Upper Calf _____

∞ Mid-Calf _____

∞ Arch (Instep) _____

Push – Pull Technology Improves Arterial Blood Flow in Lower Extremity

Every 20 seconds, the Bio Arterial device delivers a 4-second, high pressure cycle (120 mmHg) sequentially to the plantar venous plexus and the calf muscles. This rapidly pushes venous outflow towards the heart, creating a significant gradient pressure difference between the venous and arterial systems which improves arterial inflow towards the feet. This therapy releases nitric oxide resulting in vasodilation, and increased stress on endothelial cell lining to improve circulation. Patients can expect:

- ∞ **Improved pain-free walking and reduced rest pain**
- ∞ **Improved ulcer/wound healing**
- ∞ **Improved Ankle-Brachial Index (ABI)**

Contraindications:

• Phlebitis • DVT • PE • Congestive Heart Failure • Infection

Prescriber's Order & Attestation

I am the treating physician or practitioner for this patient. I have examined the patient, maintained oversight, and have determined that my patient has a medical necessity for a high-pressure, rapid inflation/deflation pneumatic compression device for treating issues involving arterial insufficiency. Please fax or email completed prescription with face sheet and clinical notes supporting the need for daily E0675 pneumatic compression therapy to VasoCARE.

Prescriber's Signature: _____ Date: _____ NPI: _____

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

Fax Prescription, Face Sheet, and Clinical Notes to 866-455-5150 or email to orders@vasocare.com

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