RX DERMALITE

Provider Instructions:
This form is a Physician's Written Order (PWO) for ordering home phototherapy products. It acts as your prescription and a statement of medical necessity. All fields are required for insurance approval.

IMS Experts, LLC - Innovative Medical Solutions
For questions, please call:
817-453-9767
Fax completed form to:
817-473-1839

Patient Info:

First Name _____ Last Name _____ DOB ____/____/____ Gender: ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Phone #_____ Alt Phone # or Email _____

Home Phototherapy Product:

HCPCs:		Product and Description:
E0691	☐	***DermaPal:*** Hand-held treatment wand for scalp, spot treatment or travel. Includes comb attachment.
E0691	☐	***1 Series:*** Small, light-weight panel for hands, face, feet, elbows, or any other localized treatment area.
E0694	☐	***7 Series/UV Series :*** Six foot tall, multi-directional unit for large areas and/or full body treatment.
_____	☐	***Other:*** _____

Prescribing Physician Info:

Physician Name _____

Practice _____

NPI# _____

Address _____

City _____ State ____ Zip _____

Phone (____)_____*Fax (____)_____

** IMPORTANT: We will use this fax number to fax the Prescriber's Dosing Guide*

Diagnosis:

ICD-10 Code:		Description:
L40 . _____	☐	Psoriasis
L80	☐	Vitiligo
_____ . ___	☐	Other: _____

ICD-10 Code Must Be Indicated

Helpful Tip: See back of page for ICD -10 Code Quick Reference Guide

Prescription:

Prescribed Lamp Type: ☐ NB UVB ☐ Other_____

FlexRx: *(Exposure Limiting Software)* ☐ No ☐ Yes, # of exposures: ☐

*FlexRx can be prescribed in **increments of 10** up to 250; if not specified, the default qty is 40.*

New! ClearLink Control Mode: *(DermaPal devices use Time Only Mode)*

☐ Prescription Guided Mode: Controller is pre-programmed with Dose/Rx

☐ Dosimetry Only Mode ☐ Time Only Mode *(All DermaPal Devices)*

Dosing Instructions:

Patient's Fitzpatrick Skin Type and Starting Dose:

Vitiligo & ☐ Type I 200 mJ	☐ Type II 300 mJ	☐ Type III 400 mJ	☐ Type IV 500 mJ	☐ Type V 700 mJ	☐ Type VI 800 mJ

Treatment Frequency:

☐ Every Other Day	☐ 2 X per Week	☐ 3 X per Week	☐ 4 X per Week	☐ Other:_____

If skin is not pink at time of next treatment, increase dose by:

☐ 10%	☐ 15%	☐ 20%	☐ Other:_____

Other Instructions:_____

☐ Daavlin Phone Training OR ☐ Fax Dosing Guide, Provider Will Instruct Patient

Statement of Medical Necessity:

Estimated Duration of Need: ___ Months (99 = Lifetime)

Body Area Affected (Check all that apply)

☐ 3 % - 10 % (Moderate) ☐ Hands (2 %)
☐ > than 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 w/ UV Light Therapy in the past?
(Either in the office or at 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
☐ Drugs or Topicals are Contraindicated or Too Expensive
☐ Distance and Travel Time to Office
☐ Co-pay Cost of Frequent In-Office Visits
☐ Unable to Take Time Away from Work or School
☐ Other:_____

Prescriber Signature:

I certify that I am the physician identified on this form. I have reviewed this Physician's 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 physician 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.

Physician Signature (Required)_____Date_____

(Stamps are not acceptable)