Prescription & Written Order For Home Phototherapy

Fax To: 214-414-2533 ▪ Email To: sales@dermitech.com

Home Phototherapy Distributor

Prescriber: This form can be used in place of a Prescription and Letter of Medical Necessity to order home phototherapy equipment. All fields are required. Please call 214-377-8144 for assistance.

Patient

Name ______________________ DOB ____/____/______

Address ______________________ Phone ______________ Gender: ☐ M ☐ F

City ______________ State ________ Zip ________ Alt Phone ______________

Prescriber

Provider Name ______________________

Practice ______________________

NPI # ______________________

Phone ______________ Fax ______________

Prescribed Device

	HCPCS	Description
☐	E0691	Hand-held UV treatment wand for scalp, spot treatment or for use when traveling.
☐	E0691	Small lightweight panel for face, hands, feet, elbows or other localized areas
☐	E0694	Six feet tall cabinet with multi-directional lamps for large areas or full-body treatment.
☐	Other	______________________

Unit Info

Lamp Type: NB-UVB (default) ☐ Other ____

Controller: Guided Mode if available, otherwise Timer Mode (default) ☐ Timer ☐ Dosimetry

Treatment Limiting: Disabled (default) Require refill code after: ☐75/80 ☐150 ☐25/30

Diagnosis & Statement of Medical Necessity

	ICD-10	Description
☐	L40.___	Psoriasis
☐	L80	Vitiligo
☐	___.___	______________

Est. Length of Need: ____ Months ☐ Lifetime

Body Area Affected (Check all that apply)

☐ 3% - 10% (Moderate) ☐ Hands (2%)

☐ > 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 with UV Light Therapy in the past? (In the office or 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

☐ Distance and Travel Time to Office

☐ Co-pay Cost of Frequent In-Office Visits

☐ Unable to Take Time Away from Work / School

☐ Other: ______________________

Signature

I certify that I am the provider identified on this form. I have reviewed this Prescription and 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 provider 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.

Provider Signature (Required) ______________________ **Date** ______________

Home Phototherapy Dosing Order
- Narrowband UVB -

Home Phototherapy Distributor

Please fax to 214-414-2533 or e-mail to sales@dermitech.com

Prescriber: This form may be used to specify a home phototherapy treatment regimen. This information will be used by Dermitech to instruct and guide your patient (if selected). Please call 214-377-8144 for assistance.

Patient

Patient Name: ____ DOB: ____/____/_________

Diagnosis: Code (ICD-10) __________ Description ______________________________

Select a Treatment Regimen

☐ **Provide training to my patient using standard guidelines according to skin type**

Select Skin Type*	Starting Dose (mJ/cm²)	Dose Increases (mJ/cm²)	Treatment Frequency
☐ I	130	15	3 times/week
☐ II	220	25	
☐ III	260	40	
☐ IV	330	45	
☐ V	350	60	
☐ VI	400	65	

☐ **Provide training to my patient using the custom regimen below**

Skin Type (I-VI)*	Starting Dose (mJ/cm² or mm:ss)	Dose Increases (mJ/cm² or % or seconds)	Treatment Frequency

*** - Vitiligo (ICD-10: L80) is treated as Fitzpatrick Skin Type I regardless of skin type checked above**

☞ Unless instructed otherwise, Dermitech's standard phototherapy treatment instructions will be used. To request a copy of these instructions, please call 214-377-8144.

☐ **Do not provide treatment instructions to my patient**
I will provide training and guidance to the patient.

Signature

I certify that I am the patient's physician or authorized by the patient's physician to provide home treatment information for the patient above. Unless instructed otherwise, the information above will be used by Dermitech to advise the patient regarding how to manage home treatments. A copy of this order will be retained as part of the patient's medical record.

Signature ____

Name (please print) ____ **Date** __________________