

# Prescription & Written Order For Aquex Iontophoresis



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

This form can be used in place of a Prescription and Letter of Medical Necessity to order a home Tap-water Iontophoresis Device. All fields are required. Please call 214-377-8144 for assistance.

Patient

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Gender:  M  F

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Prescriber

Provider Name \_\_\_\_\_

Practice \_\_\_\_\_

NPI # \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Product / Instructions

HCPCS

Description

**E1399 Aquex Tap Water Iontophoresis**

Includes: 1 Aquex digital module, 1 carrying case & treatment tray, 1 AC adapter, red and black electrode cables, 2 aluminum electrodes, and 2 dye-free, cotton treatment towels

Tap Water Iontophoresis (TWI) is a recognized medical therapy for treatment and control of hyperhidrosis. Aquex is cleared by the FDA as a medical device for the treatment of palmar, plantar, and axillary hyperhidrosis, and can be ordered only by a prescription from a licensed healthcare provider. Use 3 times weekly for 4 weeks, then reduce frequency to once per week maintenance regimen (or as otherwise directed by the patient's provider).

Signature

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

**Provider Signature (Required)**

\_\_\_\_\_

Date \_\_\_\_\_

**The patient meets the criteria for:**

**Hyperhidrosis**

Abnormally excessive sweating in the hands (palmar), feet (plantar), or under-arms (axillary)

Date of Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the patient and/or caregiver reliable, motivated and able to adhere to instructions?

Yes  No

Est. Length of Need: \_\_\_\_ Months (99=Lifetime)

Please indicate ICD-10 Diagnosis Code:

L74.51 - Primary Focal Hyperhidrosis

- L74.510 Axilla
- L74.512 Palms
- L74.513 Soles
- L74.519 Unspecified
- Other: \_\_\_\_\_

Diagnosis & Statement of Medical Necessity

**Statement of Medical Necessity**

Hyperhidrosis has a devastating effect on a patient's quality of life, causing physical discomfort, social embarrassment, and disruption of occupational and daily activities. This has been true for this patient who has suffered from hyperhidrosis for a significant length of time. Experts recommend a stepped approach to choosing therapy for hyperhidrosis. Tap water iontophoresis (TWI) is safe, effective, and has long been known to inhibit sweat production. It is the next logical choice for treating this patient's condition. Continued treatment is required to maintain effectiveness, therefore I am prescribing the purchase of an Aquex personal home TWI device. It is economical and will provide long term treatment for this patient. If denied, other treatment options include continuous Botox injections or surgery (Sympathectomy). In light of this clinical information and the patient's condition, tap water iontophoresis is medically necessary and warrants insurance coverage.