Prescription & Written Order For Home Phototherapy

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

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Daavlin Home Phototherapy Distributor

Prescriber: This form can be used in place of a Prescription and a Letter of Medical Necessity to order Daavlin home phototherapy products. 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 _____

Home Phototherapy Product

	HCPCS	Description
☐	E0691	DermaPal: Hand-held UV Wand for Scalp, Spot Treatment or Travel
☐	E0691	1 Series: 2' UV Panel for Hands, Face, and Other Localized Areas
☐	E0692	4 Series: 4' UV Panel with Multi-Directional Lamps
☐	E0693	7 Series: 6' UV Panel with Multi-Directional Lamps for Large Areas
☐	E0694	7 Series: 6' UV Cabinet with Lamps in Doors for Larger Areas
☐	E0694	UV Series: 6' UV Surround Unit for Total Body Treatment
☐	E1399	M Series: Hand and Foot Unit with Multi-Directional Lamps

Unit Info

Lamp Type: ☐ NB-UVB ☐ Other _____

Controller: ☐ Timer (default) ☐ Dosimetry

Acquisition: ☐ Purchase ☐ Rental ☐ Patient Choice

FlexRx (treatment limiting system): ☐ Yes ☐ No

If yes, how many treatments:_____
(10 to 250, default is 80)

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** _____

This form can be found at www.dermitech.com/forms

Home Phototherapy Dosing Order
- Narrowband UVB -

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

dermitech

Daavlin

Authorized Home Phototherapy Supplier

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 _____

☞ Note that Vitiligo (ICD-10: L80) is always treated as Skin Type I

Select a Treatment Regimen

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

Select Skin Type	Starting Dose (mJ/cm²)	Select Dose Increases	Treatment Frequency
❒ I	200	❒ 10% ❒ 15%	3 times/week
❒ II	300		
❒ III	400		
❒ IV	500		
❒ V	700		
❒ VI	800		

☐ **Provide training to my patient using the custom regimen below**
Daavlin will fax a detailed dosing guide when the device is shipped

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

☞ 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. Daavlin will fax a detailed dosing guide when device is shipped.

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** _____