Prescription & Written Order For Levia Home Phototherapy

dermitech

Daavlin Home Phototherapy Distributor

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

Prescriber Instructions: This form can be used in place of a Prescription and Letter of Medical Necessity to order Levia home phototherapy products. For products other than Levia, please use the general form. 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 _____

Product

	HCPCS	Description
☐	E1399	Levia Personal Targeted UVB Home Phototherapy System

Select a Treatment Regimen

	Skin Type	Dose (mJ/cm²)	Dose Increase	Frequency
☐	I	90	15%	Every 2 days
☐	II	150	15%	Every 2 days
☐	III	180	15%	Every 2 days
☐	IV	230	15%	Every 2 days
☐	V	250	15%	Every 2 days
☐	VI	280	15%	Every 2 days
Or Enter a Custom Regimen				
	I to VI	5 - 995	0 - 50%	Every 1-99 days
☐				

Diagnosis & Statement of Medical Necessity

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

Est. Length of Need: ____ Months (99=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 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

☐ 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 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 medical records 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