solventum

KCI V.A.C.® Therapy Insurance Authorization Form (v9.0)

(Do Not Substitute)

⚠ **V.A.C.® Ready Care Program Order?** ☐ Yes ☐ No

Please fax this form: **1-888-245-2295**
Customer Service: **1-800-275-4524**

1 Patient and insurance information (important: please submit demographic and/or insurance sheet)

Patient Full Name (print): _____ MI: ____ Patient DOB: ____ /____ /_____ Gender: ☐ M ☐ F

(skip these questions if demographic/insurance sheet submitted) Patient Email: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Emergency Contact (if available): _____ Phone: _____

Primary Insurance: _____ Policy#: _____ Secondary Insurance: _____ Policy#: _____

2 Prescriber information (complete in full or fax written prescription to include the following)

I prescribe V.A.C.® Therapy for the following wound type(s): ☐ Pressure Ulcer(s) ☐ Diabetic Ulcer(s) ☐ Venous Ulcer(s) ☐ Arterial Ulcer

☐ Surgically Created ☐ Other: _____

I prescribe V.A.C.® Therapy for: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ Other (weeks): _____
and up to 15 V.A.C.® Therapy dressings per wound, per month, and up to 10 V.A.C.® Therapy canisters per month.

Provide narrative description specifying wound etiology and including anatomical location(s): _____

Order Date (therapy start date): _____ /_____ /_____ ICD-10 Code(s), if available: _____

Goal at the completion of V.A.C.® Therapy: ☐ Assist in granulation tissue formation ☐ Flap ☐ Graft ☐ Delayed primary closure (tertiary)

Prescriber Name (print): Last: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Prescriber Phone: _____ Fax: _____ Email: _____ NPI: _____

☐ Request an electronically signed prescription from prescriber (sent to email address listed above).

Prescriber only to sign and date. Original prescriber signature required. Stamps and photocopies strictly prohibited.

Prescriber Signature: _____ Signature Date: ____ /____ /_____

By signing and dating, I attest that I am prescribing the V.A.C.® Negative Pressure Wound Therapy System **(DO NOT SUBSTITUTE)** as medically necessary, and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information and other instructions for use included with the V.A.C.® Therapy product, as well as the V.A.C.® Therapy Clinical Guidelines. I also understand the V.A.C.® Therapy System contraindications.

3 Supplies for delivery (please check the V.A.C.® Dressing(s) requested)

V.A.C.® Peel and Place Dressing up to 7-day wear time	☐ **Small**	☐ **Medium**	☐ **Large**
Dermatac™ Drape with V.A.C.® Granufoam™ Dressing Kit	☐ **Small**	☐ **Medium**	☐ **Large**
V.A.C.® Granufoam™ Dressing	☐ Small	☐ Medium	☐ Large
V.A.C.® Simplace™ Dressing	☐ Small	☐ Medium	
V.A.C.® Simplace™ Ex Dressing	☐ Small	☐ Medium	

V.A.C.® Granufoam™ Bridge Dressing	☐	
V.A.C.® Granufoam™ Bridge XG Dressing	☐	
V.A.C.® Whitefoam™ Dressing Foam Only	☐ Small	☐ Large
V.A.C.® Whitefoam™ Dressing Kit	☐ Small	☐ Large

Other: _____ Qty: _____

4 Requestor and Post-Acute Clinical Provider information (please complete in full)

Delivery Need By Date: ____ /____ /_____ Need By Time: _____ ☐ a.m. ☐ p.m.

Requestor Name and Title: _____ Requestor Phone: _____

Requestor Facility: _____

Address: _____ City: _____ State: _____ Zip: _____

Required: Email (for order status and follow up): _____

Delivery Location: ☐ Private Residence ☐ Facility/RM#: _____ ☐ Other: _____

Delivery Address: _____ City: _____ State: _____ Zip: _____

Location of V.A.C.® Therapy Use: ☐ Private Residence ☐ Wound Care Clinic ☐ SNF ☐ LTAC/Rehab ☐ Assisted Living

☐ Other: _____

Post-Acute Clinical Provider (responsible for dressing changes): _____ **Required: Phone:** _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Name: _____ Patient DOB: _____ /_____ /_____ Completed By: _____

5a Clinical information by wound type

1. **Was NPWT initiated in one of these in-patient facilities?** ☐ **Hospital** ☐ **LTAC** ☐ **SNF Date Initiated:** _____ /_____ /_____
   OR has the patient been on NPWT anytime during the last 60 days? ☐ **Yes** ☐ **No** **Facility Name:** _____
2. Is the patient's nutritional status compromised? ☐ Yes ☐ No Facility City/State: _____
   If Yes, check the action taken: ☐ Protein supplements ☐ Enteral/NG feeding ☐ TPN ☐ Vitamin therapy ☐ Special diet
3. Indicate other therapies that have been previously tried and/or failed to maintain a moist wound environment:
   ☐ Saline Gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid ☐ Absorptive ☐ None ☐ Other: _____
4. If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to applying V.A.C.® Therapy?
   ☐ Presence of co-morbidities ☐ High risk of infections ☐ Need for accelerated granulation tissue ☐ Prior history of delayed wound healing
   ☐ Other (please describe): _____
5. Which of the following co-morbidities apply? ☐ Diabetes ☐ ESRD ☐ PVD ☐ PAD ☐ Immunocompromised ☐ Obesity ☐ Depression
   ☐ Smoking ☐ Para ☐ Quad ☐ WC Dependent ☐ Bedbound ☐ Not Applicable
6. If above diabetes box checked, is the patient on a comprehensive diabetic management program? ☐ Yes ☐ No ☐ Not Applicable
7. Is Osteomyelitis present in wound? ☐ Yes ☐ No If yes, please indicate the following:
   ☐ Antibiotic (list name): _____ ☐ IV Antibiotics (list name): _____ ☐ Hyperbaric Oxygen
   Is the above treatment administered to the patient with the intention to completely resolve the underlying bone infection? ☐ Yes ☐ No
8. Please provide a short narrative of possible consequences if V.A.C.® Therapy is not used. (**include/attach** any clinical data such as H&P, OP report, and other medical documentation supporting treatments tried and describing factors impacting wound healing):

5b Patient's primary wound type (please select one)

☐ **Pressure Ulcer** ☐ Stage III ☐ Stage IV
1. Is the patient being turned/positioned? ☐ Yes ☐ No
2. Has a group 2 or 3 surface been used for ulcer located on the posterior trunk or pelvis? ☐ Yes ☐ No
3. Are moisture and/or incontinence being managed? ☐ Yes ☐ No
4. Is pressure ulcer greater than 30 days? ☐ Yes ☐ No

☐ **Diabetic Ulcer/Neuropathic Ulcer**
1. Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? ☐ Yes ☐ No

☐ **Venous Stasis Ulcer/Venous Insufficiency**
1. Are compression bandages and/or garments being consistently applied? ☐ Yes ☐ No
2. Is elevation/ambulation being encouraged? ☐ Yes ☐ No

☐ **Arterial Ulcer/Arterial Insufficiency**
1. Is pressure over the wound being relieved? ☐ Yes ☐ No

☐ **Surgical**
1. Was or will the wound be surgically created and not another wound type listed in section 5b? ☐ Yes ☐ No
2. Has the surgery taken place yet? ☐ Yes ☐ No
3. Date of surgical procedure involving wound: _____ /_____ /_____
4. Description of the surgical procedure pertaining to the wound: _____

☐ **If Cancer Related Wound:** Include pathology report.

☐ **Other Wound Type (describe):** _____

Please complete if applicable:

Is wound a direct result of an accident? ☐ Yes ☐ No

If Yes, complete the following: Date of Accident: _____ /_____ /_____

Accident type: ☐ Auto ☐ Employment ☐ Trauma

5c Wound(s) description

Wound #1 Type: _____ Age (months): _____
Wound Location: _____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Was debridement attempted in the last 10 days? ☐ Yes ☐ No
If yes, debridement date: _____ /_____ /_____ Type: _____
Are serial debridements required? ☐ Yes ☐ No
Measurement Date: _____ /_____ /_____
Length: _____ cm **Width:** _____ cm **Depth:** _____ cm
Appearance of wound bed and color: _____
Exudate (amount and color): _____
Is the wound full thickness? ☐ Yes ☐ No
Is muscle, tendon or bone exposed? ☐ Yes ☐ No
Is there undermining? ☐ Yes ☐ No
Location #1: _____ cm, from _____ to _____ o'clock
Location #2: _____ cm, from _____ to _____ o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1: _____ cm, at _____ o'clock
Location #2: _____ cm, at _____ o'clock

Wound #2 Type: _____ Age (months): _____
Wound Location: _____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Was debridement attempted in the last 10 days? ☐ Yes ☐ No
If yes, debridement date: _____ /_____ /_____ Type: _____
Are serial debridements required? ☐ Yes ☐ No
Measurement Date: _____ /_____ /_____
Length: _____ cm **Width:** _____ cm **Depth:** _____ cm
Appearance of wound bed and color: _____
Exudate (amount and color): _____
Is the wound full thickness? ☐ Yes ☐ No
Is muscle, tendon or bone exposed? ☐ Yes ☐ No
Is there undermining? ☐ Yes ☐ No
Location #1: _____ cm, from _____ to _____ o'clock
Location #2: _____ cm, from _____ to _____ o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1: _____ cm, at _____ o'clock
Location #2: _____ cm, at _____ o'clock