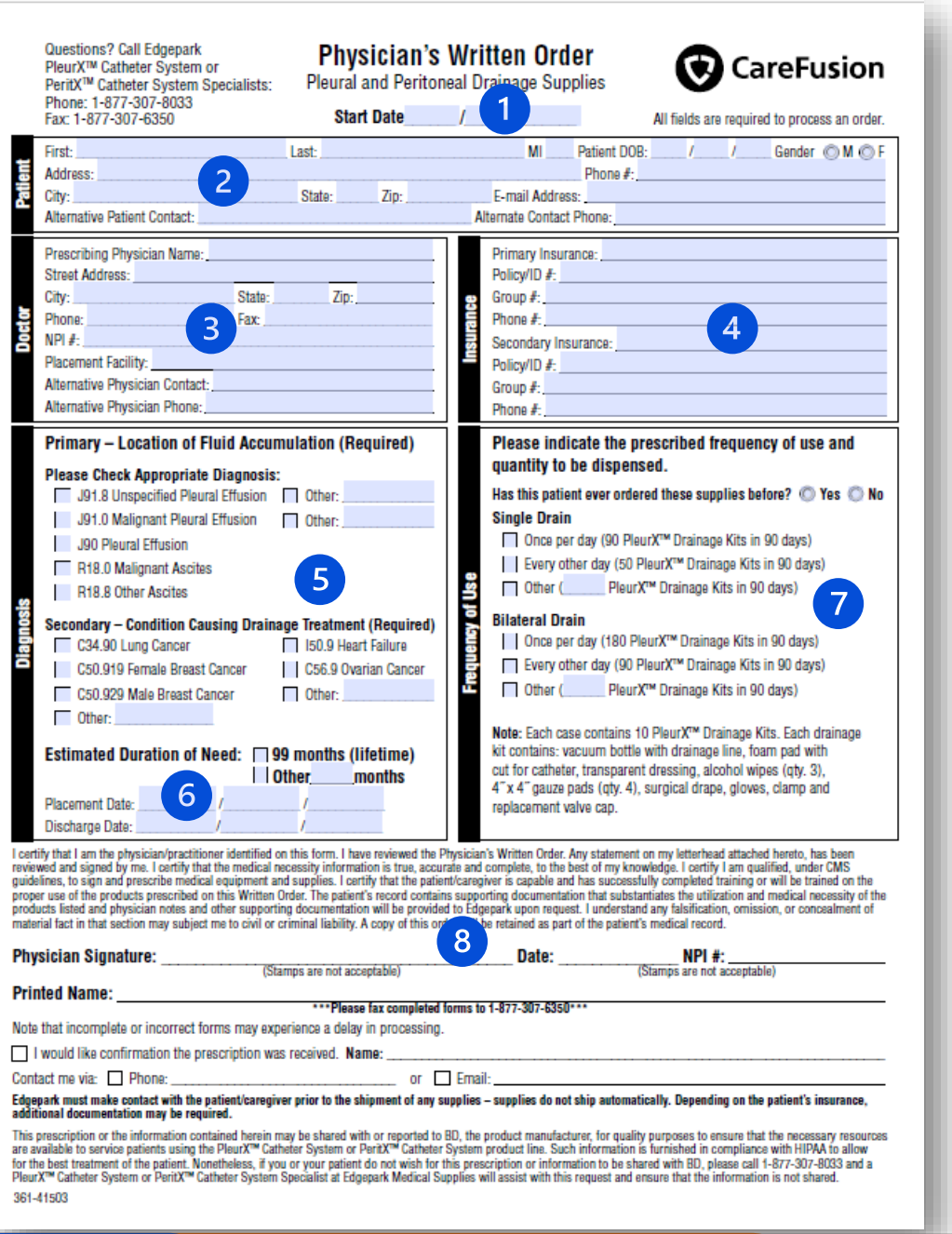

Questions? Call Edgepark
PleurX™ Catheter System or
PeritX™ Catheter System Specialists:
Phone: 1-877-307-8033
Fax: 1-877-307-6350

Physician's Written Order

Pleural and Peritoneal Drainage Supplies

CareFusion

Start Date ___/___/___ (1)

All fields are required to process an order.

Patient

First: ___ Last: ___ MI ___ Patient DOB: ___/___/___ Gender ◯ M ◯ F
Address: ___ (2) Phone #: ___
City: ___ State: ___ Zip: ___ E-mail Address: ___
Alternative Patient Contact: ___ Alternate Contact Phone: ___

Doctor

Prescribing Physician Name: ___
Street Address: ___
City: ___ State: ___ Zip: ___
Phone: ___ (3) Fax: ___
NPI #: ___
Placement Facility: ___
Alternative Physician Contact: ___
Alternative Physician Phone: ___

Insurance

Primary Insurance: ___
Policy/ID #: ___
Group #: ___
Phone #: ___ (4)
Secondary Insurance: ___
Policy/ID #: ___
Group #: ___
Phone #: ___

Diagnosis

Primary – Location of Fluid Accumulation (Required)

Please Check Appropriate Diagnosis:

- ☐ J91.8 Unspecified Pleural Effusion ☐ Other: ___
- ☐ J91.0 Malignant Pleural Effusion ☐ Other: ___
- ☐ J90 Pleural Effusion
- ☐ R18.0 Malignant Ascites (5)
- ☐ R18.8 Other Ascites

Secondary – Condition Causing Drainage Treatment (Required)

- ☐ C34.90 Lung Cancer ☐ I50.9 Heart Failure
- ☐ C50.919 Female Breast Cancer ☐ C56.9 Ovarian Cancer
- ☐ C50.929 Male Breast Cancer ☐ Other: ___
- ☐ Other: ___

Estimated Duration of Need: ☐ **99 months (lifetime)** ☐ **Other____months** (6)

Placement Date: ___/___/___
Discharge Date: ___/___/___

Frequency of Use

Please indicate the prescribed frequency of use and quantity to be dispensed.

Has this patient ever ordered these supplies before? ◯ **Yes** ◯ **No**

Single Drain

- ☐ Once per day (90 PleurX™ Drainage Kits in 90 days)
- ☐ Every other day (50 PleurX™ Drainage Kits in 90 days)
- ☐ Other (____ PleurX™ Drainage Kits in 90 days) (7)

Bilateral Drain

- ☐ Once per day (180 PleurX™ Drainage Kits in 90 days)
- ☐ Every other day (90 PleurX™ Drainage Kits in 90 days)
- ☐ Other (____ PleurX™ Drainage Kits in 90 days)

Note: Each case contains 10 PleurX™ Drainage Kits. Each drainage kit contains: vacuum bottle with drainage line, foam pad with cut for catheter, transparent dressing, alcohol wipes (qty. 3), 4" x 4" gauze pads (qty. 4), surgical drape, gloves, clamp and replacement valve cap.

I certify that I am the physician/practitioner identified on this form. I have reviewed the Physician's Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed training or 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 products listed and physician notes and other supporting documentation will be provided to Edgepark upon request. I understand any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order may be retained as part of the patient's medical record.

Physician Signature: ___ (8) **Date:** ___ **NPI #:** ___
(Stamps are not acceptable) (Stamps are not acceptable)

Printed Name: ___

Please fax completed forms to 1-877-307-6350

Note that incomplete or incorrect forms may experience a delay in processing.

☐ I would like confirmation the prescription was received. **Name:** ___

Contact me via: ☐ Phone: ___ or ☐ Email: ___

Edgepark must make contact with the patient/caregiver prior to the shipment of any supplies – supplies do not ship automatically. Depending on the patient's insurance, additional documentation may be required.

This prescription or the information contained herein may be shared with or reported to BD, the product manufacturer, for quality purposes to ensure that the necessary resources are available to service patients using the PleurX™ Catheter System or PeritX™ Catheter System product line. Such information is furnished in compliance with HIPAA to allow for the best treatment of the patient. Nonetheless, if you or your patient do not wish for this prescription or information to be shared with BD, please call 1-877-307-8033 and a PleurX™ Catheter System or PeritX™ Catheter System Specialist at Edgepark Medical Supplies will assist with this request and ensure that the information is not shared.

361-41503

1. Must have Start Date
2. Must have patient identifiers
3. Must have NPI number and prescribing physician details listed. The alternate physician contact is not necessary
4. Not required but helpful
5. Please list primary and secondary dx (if applicable)
6. Please include placement date and discharge date. Must have duration of need selected. If select other, write the number of months
7. Must have frequency of use marked. Note: if you select other you must write a number on the line next to other to indicate how many kits in a 90-day period
8. Must have Physician signature (not a stamp), Date, NPI and printed name