Physician's Written Order

Drainage Supplies for PleurX™ Pleural Catheter System and PeritX™ Peritoneal Catheter System

BD Patient Navigators
Phone: 833.549.7677
Fax: 312.949.0366
Email: GMB-PleurXPTNav-US@bd.com

*All fields are **required** to process and order.*
*Please fax completed forms to **312.949.0366**.*
Incomplete or incorrect forms may result in a delay in processing

Start Date _____

PATIENT

First: _____ Last: _____ MI: ____ Patient DOB: ____ / ____ / ____ Gender ◯ M ◯ F
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Email: _____
Alternative Patient Contact: _____ Alternative Contact Phone: _____

DOCTOR

Prescribing Physician: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI #: _____
Placement Facility: _____
Alternative Physician: _____
Alternative Physician Phone: _____

INSURANCE

Primary Insurance: _____
Policy/ID #: _____
Group #: _____
Phone: _____
Secondary Insurance: _____
Policy/ID #: _____
Group #: _____
Phone: _____

DIAGNOSIS

Primary - Location of Fluid Accumulation

Please check appropriate diagnosis:

- ◯ J91.8 Unspecified Pleural Effusion
- ◯ J91.0 Malignant Pleural Effusion
- ◯ J90 Pleural Effusion
- ◯ R18.0 Malignant Ascites
- ◯ R18.8 Other Ascites
- ◯ Other: _____
- ◯ Other: _____

Secondary - Condition Causing Drainage Treatment

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

Estimated Duration of Need:

- ◯ 99 months (lifetime)
- ◯ Other _____ months

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)

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" x4" gauze pads (qty. 4), surgical drape, gloves, clamp, and replacement valve.

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 a DME Supplier or vendor to supply products to patient 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 will be retained as part of the patient's medical record.

Physician Signature: _____ Date: _____ NPI #: _____

Printed Name: _____ *Stamps are not acceptable for signature. Please fax completed forms to 312.949.0366.*

◯ I would like confirmation the prescription was received. Name: _____

Contact me via: ◯ Phone: _____ or ◯ Email: _____

Contact must be made with the patient/caregiver prior to the shipment of any supplies – supplies do not ship automatically.
Depending on the patient's insurance or program being requested, additional documentation may be required.

BD