V.A.C.® Therapy Insurance Authorization Form v.3

KCI Customer Service: 1-800-275-4524

Please fax this form to KCI at **1-888-245-2295**

1 Patient Information (Important: Please submit demographic and/or insurance sheet)

Patient Name (print) Last: _____ First:_____ MI: _____ Patient DOB: ___/___/_____
(*skip completing patient's home address if demographic/insurance sheet submitted*)
Home Address:_____ Apt #: _____
City: _____ST:_____ Zip Code: _____ Phone #: _____
Emergency Contact (if available): _____ Phone #: _____
Primary Insurance _____Policy#_____ 2nd Ins. _____Policy# _____

2 Prescriber Information (Complete in full or fax written prescription to include the following)

I prescribe KCI V.A.C.® Therapy for the following wound type(s): | |Pressure Ulcer(s) | Diabetic Ulcer(s) |Venous Ulcer(s) | Arterial Ulcer
|__| Surgically Created | | Other _____
Provide narrative description specifying wound etiology and including anatomical location(s):_____

I prescribe KCI 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 and up to 10 V.A.C.® Therapy canisters per month.
Starting Date of V.A.C.® Therapy: ___/____/_____ (If starting therapy is blank, use my signature date as start of therapy)

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

Treating prescriber name (print) Last _____ First: _____ MI _____

Address:_____ City: _____ ST: _____ Zip: _____

Prescriber Phone: _____ Fax: _____ NPI: _____

Prescriber Only to Complete Original Signature Required. No Stamps

Prescriber Signature: _____ Date: ___/___/_____

By signing and dating, I attest that I am prescribing the KCI V.A.C.® 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 KCI V.A.C.® Therapy Clinical Guidelines. I also understand the KCI V.A.C.® Therapy System contraindications: Patients with malignancy in the wound, untreated osteomyelitis, non-enteric and unexplored fistulas, necrotic tissue with eschar present, sensitivity to silver (V.A.C. GranuFoam Silver® Dressing only). Foam dressing (GranuFoam™, Simplace™ and WhiteFoam) for the V.A.C.® Therapy System should not be placed directly in contact with exposed blood vessels, anastomotic sites, organs, or nerves. The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) state that beyond the first four months of therapy, "to justify the need for each additional month of coverage, a new prescription for each month is required," in addition to supporting medical records that document medical need

3 Supplies for Delivery

Supplies for Delivery - Please check the V.A.C.® Dressing requested

V.A.C.® Simplace™	Dressing	___	Small	Medium		V.A.C.® GranuFoam™ Bridge
V.A.C.® GranuFoam™	Dressing		Small	Medium	Large	V.A.C.® GranuFoam™ Bridge XG
V.A.C.® WhiteFoam	Dressing	___	Small	Large		

Other Dressing: _____

4 Requestor & Post-Acute Clinical Provider Information

Requestor Facility Information (Must complete in full)
Requestor's Name _____ Title: _____ Requestor Phone: _____
Facility Name: _____ Fax#:_____
Delivery Location: |__| Home |__|Facility/ RM#: _____ |__| Other_____
Delivery Address: _____City:_____State:_____Zip:_____
KCI V.A.C.® System will be used in what type of facility: ☐Private Residence ☐WCC ☐SNF ☐LTAC/Rehab ☐Assisted Living ☐Other____
Post-Acute Clinical Provider administering Dressing Changes: Name _____ Ph._____
Address: _____City:_____State:_____Zip:_____

V.A.C.® Therapy Insurance Authorization Form v.3

1-800-275-4524

Please fax this form to KCI at **1-888-245-2295**

Patient Name: _____D.O.B.:____/____/_____ Completed by: _____

5a Clinical Information by Wound Type

1. Was NPWT initiated in an inpatient facility? Yes ☐ No ☐ 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, St: _____
   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 ☐ Immobility ☐ Immunocompromised ☐ ESRD ☐ PVD ☐ PAD ☐ Obesity ☐ Smoking ☐ Depression ☐ N/A
6. If above diabetes box checked, is the patient on a comprehensive diabetic management program? ☐ Yes ☐ No ☐ N/A
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. (**Please 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 Patients Primary Wound Type

☐ **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. Wound surgically created and not represented by descriptions above? ☐ Yes ☐ No
2. Description of surgical procedure._____
3. Date of surgical procedure involving wound._____/_____/_____

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 in Months: _____
Wound Location: _____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Has debridement been attempted in the last 10 days? ☐ Yes ☐ No
If Yes, debridement date: _____/_____/_____
Debridement 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 in Months: _____
Wound Location: _____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Has debridement been attempted in the last 10 days? ☐ Yes ☐ No
If Yes, debridement date:_____/_____/_____
Debridement 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