Initiation of negative pressure wound therapy (NPWT) — Authorization form

Order date: _____

Patient information

Patient name:	Last	First	Middle initial	Date of birth:	
Home address:		City:		State:	ZIP:
Home phone:		Mobile phone:			
Patient's Humana member identification number:					

Requester information

Requester name:	Title:
Phone number:	Fax number:
Facility name:	

Prescription, attestation and treating prescriber information

This form is required unless a separate, detailed written order for NPWT is provided. Prescriber must clearly document in the patient's medical record that other modalities have been tried or clearly document why other modalities are being ruled out.

ICD-9 diagnosis code(s) — write in complete code(s): _____

❑ **I prescribe a negative pressure wound therapy pump and up to 15 wound care sets/dressing kits per wound per month and 10 canister sets per month.**

OR alternatively, I prescribe a negative pressure wound therapy pump and up to _____ (quantity) dressing kits per wound per month and _____ (quantity) canister sets per month.

Pressure setting: _____ Frequency of dressing changes: _____

Wound location and measurements MUST be documented in patient's chart notes using the format length x width x depth. Wound measurement date and unit of measure also must be included.

Supplies for delivery

For proper processing, please **choose one row/size and check one box:**

Kit size	Dressing kits		
	Foam	**Gauze**	**Other** (channel drains, Y connectors, etc.)
Small	❑	❑	❑
Medium/regular	❑	❑	❑
Large	❑	❑	❑

Note: Foam and gauze kits do not include scissors.

Other specifications: _____

Humana®

Initiation of negative pressure wound therapy (NPWT) — Authorization form

Patient name: _____ Date of birth: _____
Last First Middle initial

By signing and dating, I attest that I am prescribing negative pressure wound therapy 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 therapy clinical guidelines. Additionally, I have reviewed the information provided in this form and attest to its accuracy.

Prescriber name: _____ NPI: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Prescriber signature: _____ Date: _____

Treating prescriber's original signature and date are required (no stamps).

Delivery instructions

Requested delivery date: _____ **Requested delivery time:** _____

❑ **Hospital delivery** Hospital/facility name: _____

Room number: _____ Direct phone number to patient's room: _____

Address: _____ City: _____ State: _____ ZIP: _____

Anticipated hospital/facility discharge date (if applicable): _____

❑ **Deliver to patient's home** – same address as listed on the first page of this order form

or

❑ **Deliver to alternate location:** _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Patient follow-up care

Name of home health agency following the patient: _____

Phone number: _____ Fax number: _____

Name of wound care clinic following the patient (if applicable): _____

Phone number: _____ Fax number: _____

Common ICD-9 codes for negative pressure wound therapy

Since NPWT is not diagnosis-driven, there is no defined set of codes that must be used with this equipment. There are many ICD-9 codes for which NPWT can be used. The following is a list of commonly used codes. Presence of an ICD-9 code alone does not guarantee coverage of an NPWT device.

ICD-9	Description
454.0	Leg varicosity with ulcer
459.81	Venous insufficiency NOS
682.6	Cellulitis of leg
682.9	Cellulitis NOS
685.0	Pilonidal cyst with abscess
707.03	Pressure ulcer, lower back (coccyx, sacrum)
707.05	Pressure ulcer, buttock
707.10	Ulcer of lower limb, unspecified
707.14	Ulcer of heel and midfoot
707.24	Pressure ulcer, stage IV
729.99	Other disorders of soft tissue
894.1	Multiple and unspecified open wounds of lower limb
998.83	Nonhealing surgical wound
998.32	Disruption of external operation surgical wound
998.30	Disruption of wound, unspecified

Initiation of negative pressure wound therapy (NPWT) — Authorization form

Patient name: _____ Date of birth: _____
Last First Middle initial

Clinical information by wound type (Complete in full OR fax applicable wound history documentation)

Wound history

1. Was NPWT initiated in an inpatient facility? ❑ Yes ❑ No
2. Has the patient been on NPWT to treat this wound previously? ❑ Yes ❑ No
   Date initiated _____ Facility name _____ Facility city/state_____
3. Is the patient's nutritional status compromised? ❑ Yes ❑ No If yes, check the action taken:
   ❑ Protein supplements ❑ Enteral/NG feeding ❑ TPN ❑ Vitamin therapy ❑ Special diet
4. Does the patient have a chronic, nonhealing ulcer with lack of improvement greater than 30 days duration, despite standard wound therapy? ❑ Yes ❑ No
5. Which therapies/dressings have been tried unsuccessfully? ❑ Saline/gauze ❑ Collagen ❑ Hydrogel
   ❑ Foam ❑ Electrical stimulation ❑ Compression ❑ Alginate ❑ Hydrocolloid ❑ Absorptive
   ❑ Hyperbaric oxygen treatment ❑ None ❑ Other: _____
6. If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to applying NPWT? ❑ Presence of comorbidities ❑ High risk of infections ❑ Need for accelerated granulation of tissue ❑ Prior history of delayed wound healing ❑ Other (please describe): _____
7. Have weekly evaluations of the wound, including documentation of wound measurements (LxWxD), been conducted by a licensed medical professional? ❑ Yes ❑ No (please include/attach these evaluations.)
8. Which of the following comorbidities apply? ❑ Diabetes ❑ Immobility ❑ Immunocompromised
   ❑ ESRD ❑ PVD ❑ PAD ❑ Obesity ❑ Smoking ❑ Depression ❑ N/A
9. If the diabetes box above is checked, is the patient on a comprehensive diabetic management program?
   ❑ Yes ❑ No ❑ N/A
10. Is osteomyelitis present in the wound? ❑ Yes ❑ No If yes, please indicate the following:
    ❑ Antibiotic (list name)_____ ❑ IV antibiotics (list name) _____
    ❑ Hyperbaric oxygen
    Is the treatment above administered to the patient with the intention to completely resolve the underlying bone infection? ❑ Yes ❑ No
11. Please provide a short narrative of possible consequences if NPWT is not used. (Please include/attach any clinical data such as history and physical, operative report and other medical documentation supporting treatments tried and describing factors impacting wound healing.):_____
    _____

Patient's wound type

❑ **Traumatic:** ❑ Flap (post-op) ❑ Graft (post-op) ❑ Soft tissue/open wound ❑ Traumatic amputation
❑ Exposed bones and tendons ❑ Other (please describe): _____

Is the wound a direct result of an accident? ❑ Yes ❑ No If yes, please complete the following:

Date of accident:_____ Description of accident involving wound:_____

Is accelerated formation of granulation tissue achievable by other topical wound treatments needed? ❑ Yes ❑ No

❑ **Surgical:** ❑ Dehisced ❑ Wound with exposed hardware/bone ❑ Poststernotomy mediastinitis
❑ Postoperative disunion of abdominal wall ❑ Other (please describe): _____

Date of surgery: _____ Description of surgical procedure involving wound: _____

❑ **Pressure ulcer:** ❑ **Stage III** ❑ **Stage IV**

1. Has the patient been on an appropriate turning/positioning regimen? ❑ Yes ❑ No
2. Has the patient used appropriate pressure relief modalities for ulcer(s) located on the posterior trunk or pelvis?
   ❑ Yes ❑ No
3. Has the patient's moisture and/or incontinence been appropriately managed? ❑ Yes ❑ No

Initiation of negative pressure wound therapy (NPWT) — Authorization form

Patient name: _____ Date of birth: _____
Last First Middle initial

❑ **Diabetic ulcer or neuropathic ulcer:**
1. Has reduction of pressure on the foot ulcer been accomplished with appropriate modalities? ❑ Yes ❑ No

❑ **Venous stasis ulcer/venous insufficiency:**
1. Have compression dressings and/or garments been consistently applied? ❑ Yes ❑ No
2. Has leg elevation/ambulation been encouraged? ❑ Yes ❑ No

Wound description — Please submit supporting documentation

Wound No. 1 Type: _____
Wound age in months:_____
Is there necrotic tissue with eschar present in the wound?
❑ Yes ❑ No
Has debridement been attempted in the last 10 days?
❑ Yes ❑ No
If yes, provide debridement date: _____
Debridement type: _____
Are serial debridements required? ❑ Yes ❑ No
Measurement date: _____
Wound location: _____
Length_____cm Width_____cm Depth_____cm
Appearance of wound bed and odor:_____
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
Within the vicinity of the wound, is there:
- Cancer present? ❑ Yes ❑ No
- A fistula to an organ or body cavity? ❑ Yes ❑ No
- Active bleeding/difficult wound hemostasis? ❑ Yes ❑ No
- Exposed vital organs, nerves, arteries/veins or anastomotic sites? ❑ Yes ❑ No

Wound No. 2 Type: _____
Wound age in months:_____
Is there necrotic tissue with eschar present in the wound?
❑ Yes ❑ No
Has debridement been attempted in the last 10 days?
❑ Yes ❑ No
If yes, provide debridement date: _____
Debridement type: _____
Are serial debridements required? ❑ Yes ❑ No
Measurement date: _____
Wound location: _____
Length_____cm Width_____cm Depth_____cm
Appearance of wound bed and odor:_____
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
Within the vicinity of the wound, is there:
- Cancer present? ❑ Yes ❑ No
- A fistula to an organ or body cavity? ❑ Yes ❑ No
- Active bleeding/difficult wound hemostasis? ❑ Yes ❑ No
- Exposed vital organs, nerves, arteries/veins or anastomotic sites? ❑ Yes ❑ No

Submitting this form
This form should be submitted to Humana online. You will need to fill out and scan this document and convert it into a PDF file; then, upload it while completing an online authorization request for NPWT products.

To submit this form to Humana, sign into the secure provider portal at **Humana.com**. Then, take these steps:
1. Select the "Referral & Authorization Submission" icon.
2. Begin your submission by selecting the outpatient authorization type and filling in the other information requested by the system.
3. When you reach the "Clinical Attachments" screen, upload this completed document.
4. Complete and submit the online authorization request.

After your completed form is reviewed, a Humana nurse may call you to request supporting medical records.