Rx

Physician's Written Order For Levia Phototherapy

Fax To: 419-636-7916

For Office Use Only

Billing Entity:
- ☐ Daavlin PO Box 626 Bryan, OH 43506
- ☐ Other: ______________________

Prescriber Instructions: This form can be used in place of a Prescription and Letter of Medical Necessity **to order Levia home phototherapy units only**. (For all other home phototherapy orders, please use the Daavlin version of this form.) All fields are required. Call 800-322-8546 for assistance.

Patient:

First Name ____________ Last Name ______________ Middle Initial ____ DOB ___/___/___

Address ______________________ Phone ______________ Gender: ☐ M ☐ F

City ________________ State ______ Zip ________ Alt Phone ________________

Prescribing Doctor:

Physician Name ______________________

Practice ______________________

NPI# ______________________

Address ______________________

City ______________ State ____ Zip ______

Phone (____)__________ Fax (____)__________

Product:

HCPCs :		Description:
E1399	☐	Levia Personal Targeted UVB Home Phototherapy System

Select a Treatment Regimen:

Choose one:	Skin Type	Dose (mJ/CM²)	Increase (%)	Fequency (Every___days)
☐	I	90	15%	Every 2 days
☐	II	150	15%	Every 2 days
☐	III	180	15%	Every 2 days
☐	IV	230	15%	Every 2 days
☐	V	250	15%	Every 2 days
☐	VI	280	15%	Every 2 days
Or Enter a Custom Regimen				
	I to VI	5 - 995	0 - 50%	Every 1 - 99 days
☐				

Diagnosis & Statement of Medical Necessity:

ICD-10 :	Description / ICD-9
☐ L40 . _____	Psoriasis 696.1
☐ L80	Vitiligo 709.01
☐ ______ . ____	Other ______________

ICD-10 Code Must Be Indicated

Estimated Length of Need: 99 Months (99 = Lifetime)

Body Area Affected (Check all that apply)
- ☐ 3 % - 10 % (Moderate)
- ☐ > than 10 % (Severe)
- ☐ Other: __________ %
- ☐ Hands (2 %)
- ☐ Feet (2 %)
- ☐ Scalp (9 %)

List Previous Treatments:	Was it Effective?
______________________	☐ Yes ☐ No
______________________	☐ Yes ☐ No
______________________	☐ Yes ☐ No

Date Treatment Began: ____ / ____ / ____

Has patient ever been treated w/ UV Light Therapy in the past? (Either in the office or at home) ☐ Yes ☐ No

If yes, did the patient benefit from it? ☐ Yes ☐ No

Is the patient and/or caregiver reliable, motivated and able to adhere to instructions? ☐ Yes ☐ No

Reason for Home Use: (please check all that apply)
- ☐ Therapy is Considered Long-Term
- ☐ Distance and Travel Time to Office
- ☐ Co-pay Cost of Frequent In-Office Visits
- ☐ Unable to Take Time Away from Work or School
- ☐ Other:______________________

Signature:

I certify that I am the physician identified on this form. I have reviewed this Physician's Written Order. Any statement on my letterhead attached hereto has also been reviewed and signed by me. I certify that this patient and/or caregiver is capable and 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 product listed, and the physician notes and other supporting documentation will be provided upon request. I understand that 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 (Required)______________________Date__________
(Stamps are not acceptable)