Physician's Written Order for Home Phototherapy

Fax To: 419-636-1739

Prescriber Instructions: This form is a Prescription and Statement of Medical Necessity for Daavlin home products. Please be sure to complete all fields for insurance approval.

Patient:

Name (Last, First, MI):____

Street Address: ______________________________ City___________________ Prov_______ Code___________

Telephone: ____________________________________ DOB________________ Gender: ☐ M ☐ F

Prescribing Physician:

Physician Name: ____

Practice: _____________________________________

Address: _____________________________________ City: __________________ Prov_______ Code___________

Telephone: ____________________________________ Fax: ____

Home Phototherapy Product:

- ❑ **DermaPal:** Hand-held treatment wand for scalp and/or spot treatment.
- ❑ **Levia:** Two separate attachments for scalp and spot treatments (Fiber optic brush and Litespot).
- ❑ **1 Series:** Small, light-weight panel for hands, feet, elbows, or any other localized treatment areas.
- ❑ **M Series:** Light box for hands and feet, lamps in both hood and base of the unit.
- ❑ **7 Series:** Full body panel unit for large treatment areas.
- ❑ **UV Series:** Full body surround unit for large treatment areas.

Unit Information:

Prescribed Lamp Type:

- ❑ UVA
- ❑ Narrow Band UVB
- ❑ Other ___________

Controller Option:

- ❑ Upgrade Controller to Flex Rx
  (Not available on DermaPal or Levia)

If upgrading, how many exposures? _____
Can be prescribed in increments of 10 up to 250; default amount is 40.

- ❑ No upgrade needed

Statement of Medical Necessity:

Diagnosis:

- ❑ Psoriasis
- ❑ Vitiligo
- ❑ Eczema
- ❑ _____________

Body Area Affected:

- ❑ 3% to 10% (Moderate)
- ❑ > than 10% (Severe)
- ❑ Hands (2%)
- ❑ Feet (2%)
- ❑ Scalp (2%)

List Previous Treatments:	**Was it Effective?**
________________________________	❑ **Yes** ❑ **No**
________________________________	❑ **Yes** ❑ **No**

Reason for Home Use: (Please check all that apply)

- ❑ Therapy is considered long-term
- ❑ Long distance and travel time to and from work
- ❑ Unable to take time away from school

Number of Treatments per week ____________________ **Duration of Treatments** ________________________

Signature

I certify that I am the physician identified on this form and have reviewed the above information on this Physician's Written Order. Any statement either stamped by my office or on my letterhead attached hereto has also been reviewed and signed by me. The patient's records contain supporting documentation that substantiates the utilization and medical necessity of the product listed. I understand that any falsification, omission, or concealment of material fact in that section may subject to civil or criminal liability. A copy of this order will be retained as a part of the patient's medical record.

Physician's Signature **(Required)** ____