

Questions? Call Edgepark  
PleurX™ Specialists:  
Phone: 1-877-307-8033  
Fax: 1-877-307-6350

# Physician's Written Order

## Pleural Drainage Supplies



Start Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

All fields are required to process an order.

<b>Patient</b>	First: _____ Last: _____ MI _____ Patient DOB: _____ / _____ / _____ Gender <input type="radio"/> M <input type="radio"/> F
	Address: _____ Phone #: _____
	City: _____ State: _____ Zip: _____ E-mail Address: _____
	Alternative Patient Contact: _____ Alternate Contact Phone: _____

<b>Doctor</b>	Prescribing Physician Name: _____
	Street Address: _____
	City: _____ State: _____ Zip: _____
	Phone: _____ Fax: _____
	NPI #: _____
	Placement Facility: _____
	Alternative Physician Contact: _____ Alternative Physician Phone: _____

<b>Insurance</b>	Primary Insurance: _____
	Policy/ID #: _____
	Group #: _____
	Phone #: _____
	Secondary Insurance: _____
	Policy/ID #: _____ Group #: _____ Phone #: _____

<b>Diagnosis</b>	<b>Primary – Location of Fluid Accumulation (Required)</b>
	<b>Please Check Appropriate Diagnosis:</b>
	J91.8 Unspecified Pleural Effusion      Other: _____
	J91.0 Malignant Pleural Effusion      Other: _____
	J90 Pleural Effusion
	R18.0 Malignant Ascites
	R18.8 Other Ascites
	<b>Secondary – Condition Causing Drainage Treatment (Required)</b>
	C34.90 Lung Cancer      I50.9 Heart Failure
	C50.919 Female Breast Cancer      C56.9 Ovarian Cancer
C50.929 Male Breast Cancer      Other: _____	
Other: _____	
<b>Estimated Duration of Need:      99 months (lifetime)</b>	
<b>Other _____ months</b>	
Placement Date: _____ / _____ / _____	
Discharge Date: _____ / _____ / _____	

<b>Frequency of Use</b>	<b>Please indicate the prescribed frequency of use and quantity to be dispensed.</b>
	<b>Has this patient ever ordered these supplies before?</b> <input type="radio"/> Yes <input type="radio"/> No
	<b>Single Drain</b>
	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)
	<b>Bilateral Drain</b>
	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)
<b>Note:</b> 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" x 4" gauze pads (qty. 4), surgical drape, gloves, clamp and replacement valve cap.	

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 Edgepark 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 #:** \_\_\_\_\_  
(Stamps are not acceptable) (Stamps are not acceptable)

**Printed Name:** \_\_\_\_\_

\*\*\*Please fax completed forms to 1-877-307-6350\*\*\*

Note that incomplete or incorrect forms may experience a delay in processing.

I would like confirmation the prescription was received. **Name:** \_\_\_\_\_

Contact me via:  Phone: \_\_\_\_\_ or  Email: \_\_\_\_\_

**Edgepark must make contact with the patient/caregiver prior to the shipment of any supplies – supplies do not ship automatically. Depending on the patient's insurance, additional documentation may be required.**

This prescription or the information contained herein may be shared with or reported to BD, the product manufacturer, for quality purposes to ensure that the necessary resources are available to service patients using the PleurX product line. Such information is furnished in compliance with HIPAA to allow for the best treatment of the patient. Nonetheless, if you or your patient do not wish for this prescription or information to be shared with BD, please call 1-877-307-8033 and a PleurX Specialist at Edgepark Medical Supplies will assist with this request and ensure that the information is not shared.