

# The V.A.C.® Fast Prescription Form (Negative Pressure Wound Therapy)



Prescriber attestation may not be completed by the supplier.

PRESCRIPTION FOR V.A.C.® THERAPY

**PRESCRIBER ATTESTATION**

Patient Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (mi) \_\_\_\_\_

Patient's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I prescribe V.A.C.® Therapy and up to 15 dressings per wound and up to 10 canisters per month for \_\_\_\_\_ months, starting on \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yy  
for the following diagnosis (ICD-9 or narrative) \_\_\_\_\_

**Per CMS policy, the prescriber must sign and date the prescription prior to delivery of the V.A.C.® System.**

Prescriber signature (no stamps) \_\_\_\_\_ Date (no stamps) \_\_\_\_\_

*By my signature, I attest that V.A.C.® Therapy is medically necessary and all other applicable treatments have been tried or considered and ruled out. V.A.C.® Therapy is contraindicated with malignancy in the wound, untreated osteomyelitis, non-enteric and unexplored fistula, and/or necrotic tissue with eschar present. I am not placing a V.A.C.® dressing over exposed blood vessels or organs.*

Delivery Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ Insurance Name \_\_\_\_\_ Insurance #/HIC # \_\_\_\_\_  
mm dd yy

Delivery site type:  Residence  Wound Care Center  SNF/LTAC  Hospital  Other \_\_\_\_\_

Prescriber's goal for completion of Therapy:  Promote granulation formation  Flap  Graft  Delayed primary closure (tertiary)

Complete epithelialization (explain why) \_\_\_\_\_  Other \_\_\_\_\_

Printed prescriber name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (mi) \_\_\_\_\_

Prescriber address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_ UPIN # \_\_\_\_\_

**If the clinical condition of the wound(s) requires more than 15 dressings per wound or 10 canisters per month, a Letter of Medical Necessity must be completed by the clinician. If V.A.C.® Therapy is required for greater than 4 months, a Letter of Medical Necessity is required.**

WOUND TYPES AND SUPPLIES

**1) Please select the primary wound type(s) covered by this prescription, even if debrided:**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Pressure Ulcer (stage III or IV) | <input type="checkbox"/> Arterial Ulcer (arterial insufficiency) | <input type="checkbox"/> Amputation – Diabetic  | <input type="checkbox"/> Necrotizing Fasciitis                 |
| <input type="checkbox"/> Diabetic Ulcer                   | <input type="checkbox"/> Venous Stasis Ulcer                     | <input type="checkbox"/> Amputation – Traumatic | <input type="checkbox"/> Fistula, Enteric*                     |
| <input type="checkbox"/> Surgical                         | <input type="checkbox"/> Trauma (orthopedic)                     | <input type="checkbox"/> Graft (post op)        | <input type="checkbox"/> Burns (partial thickness/2nd degree)* |
| <input type="checkbox"/> Dehisced (disrupted)             | <input type="checkbox"/> Trauma (soft tissue/open wounds)        | <input type="checkbox"/> Flap (post op)         | * Not currently covered by Medicare                            |

**2) V.A.C.® Therapy Dressing Types: Please select needed V.A.C.® Therapy pump and dressing type**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> <b>V.A.C.® Classic</b> | <input type="checkbox"/> V.A.C.® GranuFoam® Small (10 x 7.5 x 3.3 cm)   | <input type="checkbox"/> <b>V.A.C.® Freedom®</b> | <input type="checkbox"/> V.A.C.® GranuFoam® Small (10 x 7.5 x 3.3 cm)   |
| • Non-ambulatory pt.                            | <input type="checkbox"/> V.A.C.® GranuFoam® Medium (18 x 12.5 x 3.3 cm) | • Ambulatory pt.                                 | <input type="checkbox"/> V.A.C.® GranuFoam® Medium (18 x 12.5 x 3.3 cm) |
|   | <input type="checkbox"/> V.A.C.® GranuFoam® Large (26 x 15 x 3.3 cm)    |  | <input type="checkbox"/> V.A.C.® GranuFoam® Large (26 x 15 x 3.3 cm)    |
|   | <input type="checkbox"/> V.A.C.® Vers-foam Small (10 x 7.5 x 1 cm)      |  | <input type="checkbox"/> V.A.C.® GranuFoam® Thin (26 x 15 x 1.6 cm)     |
|   | <input type="checkbox"/> V.A.C.® Vers-foam Large (10 x 15 x 1 cm)       |  | <input type="checkbox"/> V.A.C.® GranuFoam® Round (5 x 1.5 in)          |
|   | <input type="checkbox"/> Other _____                                    |  | <input type="checkbox"/> V.A.C.® GranuFoam® Heel                        |
|   |   |  | <input type="checkbox"/> V.A.C.® Vers-foam Small (10 x 7.5 x 1 cm)      |
|   |   |  | <input type="checkbox"/> V.A.C.® Vers-foam Large (10 x 15 x 1 cm)       |
|   |   |  | <input type="checkbox"/> Other _____                                    |

V.A.C.® GranuFoam® (Black polyurethane foam used to assist in granulation formation and exudate removal.)  
V.A.C.® Vers-foam (White polyvinyl alcohol foam ideally used in tunnels, undermining and on grafts.)

ORDER CONTACT

**Please list the name of the person placing this V.A.C.® Therapy order in case KCI requires follow-up.**

Contact name (please print) \_\_\_\_\_ Title \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Facility name \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_

**For KCI Use Only.**  
KCI Home/Extended RO# \_\_\_\_\_ KCI Acute RO# \_\_\_\_\_ Account # \_\_\_\_\_

**Please fax this completed form along with The V.A.C.® Fast Demographic Form and The V.A.C.® Fast Clinical Form to 1-888-245-2295.  
Please file the original in the provider's patient record.**

KCI offers two choices in accepting information for a V.A.C.<sup>®</sup> Therapy order. Delivery times are equal for both processes. These flexible options allow our customers to collect and submit the information in the easiest possible manner for them. Information may be submitted all at once in our “Single Submission Process” or in two stages in our “Double Submission Process.” Medicare requires that V.A.C.<sup>®</sup> Therapy be released only after the receipt of a complete “prior written order.” KCI collects patient information for the purposes of fulfilling the order and determining whether the patient meets government or private payor coverage criteria.

## PLEASE CHOOSE YOUR PREFERRED PROCESS

### SINGLE SUBMISSION PROCESS

#### 1 Complete The V.A.C.<sup>®</sup> Fast Prescription Form

- Clinician or prescriber completes form
- Prescriber signs and dates form

#### 2 Collect Patient's Demographic Information

- Complete The V.A.C.<sup>®</sup> Fast Demographic Form  
- OR -
- Submit documentation from patient chart\* detailing:
  - Patient information
  - Primary and secondary insurance
  - Prescriber contact information
  - Ordering clinician contact information
  - Delivery site contact information

#### 3 Collect Patient's Clinical Information

- Complete The V.A.C.<sup>®</sup> Fast Clinical Form
- Use additional copies of The V.A.C.<sup>®</sup> Fast Clinical Form if patient has 3 or more wounds  
- OR -
- Submit documentation from patient chart\* detailing the patient's record of evaluation, care and wound measurements

#### 4 Fax ALL Documents to 888-245-2295

### DOUBLE SUBMISSION PROCESS

#### 1 Complete The V.A.C.<sup>®</sup> Fast Prescription Form

- Clinician or prescriber completes form
- Prescriber signs and dates form

#### 2 Fax Rx to 888-245-2295

#### 3 Collect Patient's Demographic Information

- Complete The V.A.C.<sup>®</sup> Fast Demographic Form  
- OR -
- Submit documentation from patient chart\* detailing:
  - Patient information
  - Primary and secondary insurance
  - Prescriber contact information
  - Ordering clinician contact information
  - Delivery site contact information

#### 4 Collect Patient's Clinical Information

- Complete The V.A.C.<sup>®</sup> Fast Clinical Form
- Use additional copies of The V.A.C.<sup>®</sup> Fast Clinical Form if patient has 3 or more wounds  
- OR -
- Submit documentation from patient chart\* detailing the patient's record of evaluation, care and wound measurements

#### 5 Fax Clinical and Demographic Documents to 888-245-2295 within 24 hours of Step 2

\* **NOTE:** Depending on how your organization charts, source documents may include some or all of the following: face sheet, nursing and physician progress notes, H&P, operative reports, lab reports, radiology reports, nutritional assessments and/or dietary consult notes, discharge summary, wound flow sheets or assessments, OASIS data, or other as necessary.



# The V.A.C.® Fast Clinical Form (Negative Pressure Wound Therapy)

Phone: 800-275-4524  
Fax: 888-245-2295



Patient Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of person completing form \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Wound Profile information in these sections may not be completed by the supplier. If more than two wounds are to be treated, additional Clinical Information page(s) are required.

PATIENT AND  
WOUND INFORMATION

1) Was V.A.C.® Therapy initiated in an inpatient facility? If YES, complete the following information. If NO, go to 2a:  Yes  No

Facility Name \_\_\_\_\_

Date V.A.C.® Therapy was initiated in this facility (mm/dd/yy) \_\_\_\_/\_\_\_\_/\_\_\_\_

2a) Is there anything compromising the patient's nutritional status? If YES, answer B; if NO, go to question 3a.  Yes  No

2b) If YES, what measures have been taken?

- Protein Supplements  Enteral/NG Feeding  TPN
- Vitamin Therapy  Special Diet
- Other \_\_\_\_\_

3a) Is V.A.C.® Therapy being ordered for any type of chronic wound (> 30 days)? If YES, answer B, if NO, go to 4.  Yes  No

3b) If YES, which previous therapies have been applied to maintain a moist wound environment?

- Saline Soaked Gauze  Hydrogel  Alginate
- Hydrocolloid  Absorptive  Other \_\_\_\_\_

4) Is the patient on a comprehensive diabetic management program?

- Yes  No  N/A

WOUND TYPE INFORMATION

5) Wound Type – Complete only the section for the type of wound being treated. If more than two wounds are being treated, additional Clinical Information page(s) are required.

5a)  ULCERS, PRESSURE:  Stage III  Stage IV

Is the patient being turned and positioned?  Yes  No

Is a specialized support surface being utilized for ulcers on the posterior trunk or pelvis?  Yes  No  N/A

Is moisture/incontinence being managed?  Yes  No  N/A

5b)  ULCERS, DIABETIC AND/OR NEUROPATHIC:

Is foot ulcer pressure being reduced?  Yes  No  N/A

5c)  WOUNDS, TRAUMATIC, SURGICALLY CREATED, OR DEHISCED:

Is the wound a direct result of an accident?  Yes  No

Cause of accident:  Auto  Employment  Abuse

Another party responsible  Other \_\_\_\_\_

Date of accident \_\_\_\_\_

5d)  ULCERS, VENOUS STASIS:

Are compression bandages/garments being consistently applied?  Yes  No

Is leg elevation/ambulation being encouraged?  Yes  No

5e)  ULCERS, CHRONIC, INCLUDING ARTERIAL INSUFFICIENCY:

Is pressure over the wound being relieved?  Yes  No  N/A

Is moisture/incontinence being controlled?  Yes  No  N/A

\* If you answered NO to any of the questions in 5a, 5c, 5d or 5e, please explain:

WOUND MEASUREMENT

6a) Wound # \_\_\_\_, Type: \_\_\_\_\_ Measurement Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yy

i) Has all eschar been removed from the wound?  Yes  No

ii) Is there less than 20% slough/fibrin in the wound?  Yes  No

If i or ii is No, are serial debridements required?  Yes  No

Wound Age (mos): \_\_\_\_\_ Location \_\_\_\_\_

L: \_\_\_\_\_ cm W: \_\_\_\_\_ cm D: \_\_\_\_\_ cm If wound depth varies, document the greatest depth.

Exudate: \_\_\_\_\_ ml/day (if available). Sinus/Tunnel #1: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock.

Sinus/Tunnel #2: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock. Sinus/Tunnel #3: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock.

Undermining #1: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock. Undermining #2: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock.

6b) Wound # \_\_\_\_, Type: \_\_\_\_\_ Measurement Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yy

i) Has all eschar been removed from the wound?  Yes  No

ii) Is there less than 20% slough/fibrin in the wound?  Yes  No

If i or ii is No, are serial debridements required?  Yes  No

Wound Age (mos): \_\_\_\_\_ Location \_\_\_\_\_

L: \_\_\_\_\_ cm W: \_\_\_\_\_ cm D: \_\_\_\_\_ cm If wound depth varies, document the greatest depth.

Exudate: \_\_\_\_\_ ml/day (if available). Sinus/Tunnel #1: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock.

Sinus/Tunnel #2: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock. Sinus/Tunnel #3: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock.

Undermining #1: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock. Undermining #2: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock.

6c) If wound length, width or depth information (i.e., a flap, graft or stasis ulcer without significant depth) is non-applicable, please explain:

For KCI Use Only.

KCI Home/Extended RO# \_\_\_\_\_ KCI Acute RO# \_\_\_\_\_ Account # \_\_\_\_\_

Please fax this completed form along with The V.A.C.® Fast Prescription Form and The V.A.C.® Fast Demographic Form to 1-888-245-2295. Please file the original in the provider's patient record. For more information, call 1-800-275-4524.



# The V.A.C.® Fast Demographic Form (Negative Pressure Wound Therapy)

Phone: 800-275-4524  
Fax: 888-245-2295



**PATIENT INFORMATION**

Patient Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (mi) \_\_\_\_\_ Birth Date     /    /      Male  Female  
Permanent Address \_\_\_\_\_ Phone # at this address (\_\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_ The V.A.C.® Therapy will be used in a:  Private Residence/Assisted Living  Nursing Home/LTAC

**PRIMARY INSURANCE**

Medicare  Private Insurance (Name) \_\_\_\_\_ HIC/ID # (if applicable) \_\_\_\_\_  
Group # (if applicable) \_\_\_\_\_ Group Name (if applicable) \_\_\_\_\_ Policy # (if applicable) \_\_\_\_\_  
Phone # (\_\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_\_) \_\_\_\_\_  
Insured's Name (if different from patient) \_\_\_\_\_ Birth Date     /    /      Male  Female  
Address (if different from patient) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship to patient  Child  Spouse  Other \_\_\_\_\_

**SECONDARY INSURANCE**

Supplemental/Secondary Insurance Name (if any) \_\_\_\_\_ HIC/ID # (if applicable) \_\_\_\_\_  
Group # (if applicable) \_\_\_\_\_ Group Name (if applicable) \_\_\_\_\_ Policy # (if applicable) \_\_\_\_\_  
Phone # (\_\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_\_) \_\_\_\_\_  
Insured's Name (if different from patient) \_\_\_\_\_ Birth Date     /    /      Male  Female  
Address (if different from patient) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship to patient  Child  Spouse  Other \_\_\_\_\_

**CLINICAL CARE CONTACT**

Full name of organization that will be providing clinical care (e.g., dressing changes) \_\_\_\_\_  
Address \_\_\_\_\_ Org. Phone # (\_\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Fax # (\_\_\_\_\_) \_\_\_\_\_  
Contact Name \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_ E-mail Address (optional) \_\_\_\_\_  
Delivery Site Contact (if different) \_\_\_\_\_ Phone # at delivery site (\_\_\_\_\_) \_\_\_\_\_  
Delivery Address (if different) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**For KCI Use Only.**  
KCI Home/Extended RO# \_\_\_\_\_ KCI Acute RO# \_\_\_\_\_ Account # \_\_\_\_\_

Please fax this completed form along with The V.A.C.® Fast Prescription Form and The V.A.C.® Fast Clinical Form to 1-888-245-2295.  
Please file the original in the provider's patient record. For more information, call 1-800-275-4524.