DermaWound USA
Tucson, Arizona 85745

Letter of Medical Necessity and Pharmacy Prior-Authorization Forms
DermaWound® Brand Products

Email to: contact@dermawound.com

PROVIDER INSTRUCTIONS FOR LETTER OF MEDICAL NECESSITY

Note: WE CAN ONLY PROCESS COMPLETED FORMS
(Any incomplete sections will result in a delay in processing)

This compound medication request form applies to all requests for DermaWound products. Participating providers should use this form to request authorization for compound medications for the clients wound care **pharmacy benefit**.

This form is used for pre-authorization of over-the-counter compounded wound care therapy. DermaWound USA wound care products (DermaWound Original and Venous Stasis Formulas) are specifically indicated for stage 3 and stage 4 decubitus ulcers, non-healing wounds, venous stasis leg ulcers, diabetic wounds and other complex wounds.

Please call us at 1-520-490-5115 with any questions about Prior Authorizations requests.

1. Please allow at least 24 hours to review this request. If you have any questions regarding the pre-authorization request, you can contact us at 1-520-490-5115. DermaWound USA may dispense up to a 72-hour supply while awaiting the outcome of this request. To request a 72-hour supply the pharmacy must contact us at 1-520-490-5115.
2. Access our website at: https://www.DermaWound.com to access instructions and Prior Authorization (PA) forms.
3. ICD/diagnosis code is required for all requests.

Review Criteria
Requests for PA's are often based upon documented medical necessity. DermaWound is a compounded FDA Registered OTC medication with an NDC code that may have additional criteria for authorization from a client's insurance / Payor source. In those cases, the additional questions will be faxed to the requesting provider office. **Copies of office notes and medical records may also be requested.**

We use the following criteria in reviewing medication requests. Documentation is required for approval including name of medication, dates of trial(s) and reason(s) for discontinuation.

1. The use of preferred or formulary drugs is contraindicated in the patient. Please provide reason for contraindication.
2. The patient has failed an appropriate trial of preferred or formulary drugs or related agents.
3. The choices available in the formulary are not suitable for the patient. The selected drug is required for patient safety.
4. The use of a formulary drug may provoke an underlying medical condition, which would be detrimental to care.

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CLIENT INFORMATION

Request for Support:

❑Prior Authorization ❑Appeal ❑New Wound ❑Additional Applications Page _____ of _____

Last Name **First Name** **MI**	**Date of Birth**	**Age:**	**Sex:** ❑ M ❑ F
Street Address:	**City**	**State & Zip**	**Phone:**
Client's Place of Residence: ☐ Home ☐ Nursing Facility ☐ Other		**Height**	**Weight**

CLIENT INSURANCE / PAYOR INFORMATION

Primary Insurer:	Plan Type/Name:	Subscriber Name:	Relationship to Patient
Insurer Phone #:	Insurer Contact (if known):	Policy ID #:	Group #:
Secondary Insurer:	Subscriber Name:	Insurer Phone #:	Policy ID #:

PRESCRIBER INFORMATION

Last Name **First Name** **MI**		**NPI #** (required)	**DEA/License#**
Address Where Service Rendered		**City**	**State**
ZIP Code	**Telephone #**	**Fax #**	
Office Contact Name		**Contact Direct Phone #**	

EZ MEDICAL SOLUTIONS, LLC INFORMATION

Name	**Pharmacy NPI #**	**Telephone #**	**Email/Fax**

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CLINICAL INFORMATION

Specify the applicable (ICD-10) Diagnosis Code(s): ***(Refer to ICD-10 addendum for list of codes)** **❑ Diabetic Codes: _____** **❑ Chronic Ulcer: _____** **❑ Pressure Ulcer: _____** **❑ Site of Ulcer: _____** **❑ Other Wound: _____**	**❑ 2x2's ❑ 4x4's ❑ ABD's ❑ Cotton tipped applicators** **❑ Wound Cleanser ❑ Wound Gel ❑ Drain Sponges** **❑ Saline ❑ Gloves: ❑ Sterile ❑ Non-sterile** **❑ Hydrocolloids ❑ Kerlix size _____ ❑ Nu-gauze** **❑ Tape _____ ❑ Transparent dressings** **❑Other _____** **Quantity: _____ Duration: _____** **Quantity: _____ Duration: _____** **Quantity: _____ Duration: _____**

Drug(s) Name & Weight: DermaWound Original ❑ 1.0 oz tube ❑ 6.0 oz tube
DermaWound Venous Stasis ❑ 1.0 oz tube ❑ 6.0 oz tube

Wound Orders #1:	**Wound Orders #2:**
Wound #1: _____	Wound #2: _____
Site: _____	Site: _____
Type: _____	Type: _____
Status: _____	Status: _____
Length (cm): _____	Length (cm): _____
Width (cm): _____	Width (cm): _____
Depth (cm): _____	Depth (cm): _____
Drainage Odor: _____	Drainage Odor: _____
Drainage Amount: _____	Drainage Amount: _____
Drainage Type: _____	Drainage Type: _____
Stage: _____	Stage: _____
Wound Bed: _____	Wound Bed: _____
Tunneling: _____	Tunneling: _____
Undermining: _____	Undermining: _____
Surrounding Tissue: _____	Surrounding Tissue: _____
Duration of Treatment: _____	Duration of Treatment: _____
Treatment Orders	**Treatment Orders**
Clean wound bed with: _____	**Clean wound bed with: _____**
Apply: DermaWound to: ❑ Wound Bed ❑ Leg Ulcer	**Apply: DermaWound to: ❑ Wound Bed ❑ Leg Ulcer**
Other: _____	**Other: _____**
❑ Apply per manufactures instructions	**❑ Apply per manufactures instructions**
Cover with _____	Cover with _____
Secure with: _____	Secure with: _____
Change (indicate frequency and durations): _____	Change (indicate frequency and durations): _____
❑ Discontinue treatment when wound healed	❑ Discontinue treatment when wound healed

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Wound Orders #3:	**Wound Orders #4:**
Wound #3: _____	Wound #4: _____
Site: _____	Site: _____
Type: _____	Type: _____
Status: _____	Status: _____
Length (cm): _____	Length (cm): _____
Width (cm): _____	Width (cm): _____
Depth (cm): _____	Depth (cm): _____
Drainage Odor: _____	Drainage Odor: _____
Drainage Amount: _____	Drainage Amount: _____
Drainage Type: _____	Drainage Type: _____
Stage: _____	Stage: _____
Wound Bed: _____	Wound Bed: _____
Tunneling: _____	Tunneling: _____
Undermining: _____	Undermining: _____
Surrounding Tissue: _____	Surrounding Tissue: _____
Duration of Treatment: _____	Duration of Treatment: _____
Treatment Orders	**Treatment Orders**
Clean wound bed with: _____	**Clean wound bed with: _____**
Apply: DermaWound to: ❑ Wound Bed ❑ Leg Ulcer	**Apply: DermaWound to: ❑ Wound Bed ❑ Leg Ulcer**
Other: _____	**Other: _____**
❑ Apply per manufactures instructions	**❑ Apply per manufactures instructions**
Cover with _____	Cover with _____
Secure with: _____	Secure with: _____
Change (indicate frequency and durations): _____	Change (indicate frequency and durations): _____
❑ Discontinue treatment when wound healed	❑ Discontinue treatment when wound healed

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☐ **Have any other medications not listed above been tried to treat this condition?** ☐ Yes ☐ No.

If Yes, did Client experience any of the below to medications tried previously?

☐ Allergic response - Medication_____Date & Details: _____

☐ Adverse reaction - Medication_____Date & Details_____

☐ Please send copy of completed FDA MedWatch form for allergic or adverse reactions

☐ Inadequate response - Medication_____Date & Details_____

☐ Contraindication - Medication_____Date & Details: _____

☐ Drug-Drug interaction - Medication_____Date & Details: _____

☐ Patient's condition is clinically stable and changing the medication may cause deterioration of the patient's condition.
☐ How long has Client been stable on current medication? _____

☐ **Describe below medical necessity for non-preferred medication(s) or for prescribing outside of FDA labeling.**
☐ **See Attached Clinical Note for a List of All Current Medications, including dose and frequency.**
☐ **Describe below other clinical rationale to support use of the requested medication (see Chart Narrative attached).**
☐ **Describe below Medical Necessity for non-preferred medication(s) or for prescribing outside of FDA labeling.**

☐ **DermaWound Original and/or Venous Stasis formulations are clinically indicated and medically necessary when other forms of Medical treatment have been tried and are unsuccessful at meeting clinical treatment goals. Complex comorbidities and specific medical rational have been examined by this provider for the patient's specific wounds and clinical presentation. DermaWound Original and/or DermaWound Venous Stasis Compounded Medication is clinically indicated related to the medical rational described above.**

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RELEVANT DIAGNOSTIC STUDIES AND/OR LABORATORY TESTS PERFORMED
(List all tests done within past 90 days that are related to diagnosis for medication requested.)

LABORATORY ANALYSIS (LABS):			**DIAGNOSTIC TESTING:**		
Test	Date	Result	Procedure	Date	Result

Additional Comments:

By checking the following box, I certify that applying the standard review time frame may seriously jeopardize my patient's life, health, or ability to attain, maintain, or regain maximum function.

❑ Request for urgent review

PHYSICIAN'S CERTIFICATION: I certify that the use of _____ treatment for the clinical application indicated above is medically necessary and the information is accurate to the best of my knowledge.

I authorize DermaWound USA and any of its third-party contractors to be my designated agent and provide any information on this form to the Insurer of the named patient for purposes of providing reimbursement or appeals support.

Physician Name (print)	**Physician's Signature** (or Authorized Personnel)	**Date:**