ADVANCED RECOVERY SPECIALISTS

PRESCRIBER'S PRESCRIPTION

CIRCUL8 LITE DVT PROPHYLAXIS

Rx

CONTACT INFORMATION:

PLEASE FAX OR EMAIL COMPLETED FORM TO: Fax: **248.487.9442** Email: **sales@advancedrecover.com**

FOR BILLING QUESTIONS: **573.214.2061 (EXT. 1077)** FOR INQUIRIES, PLEASE CALL: **248.499.0705**

PATIENT:

Patient Name:

ICD-10 Code:

Product: DVT Prophylaxis **Sx Date:**

Duration: ☐ 21 Days ☐ other_____

Orientation: Bilateral

PRESCRIPTION INFORMATION:

☐ **DVT Prophylaxis, E0676 Deemed Medically Necessary**

I have prescribed an intermittent, sequential compression, mechanical prophylaxis therapy device for the prevention of Deep Venous Thrombosis(DVT) and/or a Pulmonary Embolism (PE). Due to the patient's restricted mobility and elevated risks this device is medically necessary. This device will provide increased blood circulation, decreased swelling and inflammation. I consider this mechanical prophylaxis to be an effective protocol in the postoperative prevention of a DVT or PE event.

☐ In my evaluation, this patient assesses to have a risk of developing Deep Venous Thrombosis (DVT) as a result of surgery. Due to that risk, I am prescribing a pneumatic compression device prophylaxis for this patient following surgery as DVT and/or pulmonary embolism (PE) are serious complications that are frequently encountered in medical and surgical practice. I feel this is a beneficial and cost effective treatment for my patient, and certify that this product is medically necessary to treat the specific medical condition discussed above. It is essential for the patient to use the pneumatic compressor and compression wraps as indicated for the specific period of time and at the prescribed pressure.

☐ I am prescribing a pneumatic compressor and compression wraps to maximize the outcome of surgery and minimize the likelihood of complications. I feel this is beneficial and cost effective treatment for my patient. It is essential for the patient to use the pneumatic compressor and compression wraps as indicated for the specific period of time and at the prescribed pressure.

PRESCRIBER INFORMATION:

Dispense As Written (DAW), Do Not Substitute: I am prescribing my patient a compression device. I have chosen the device because of its specific clinical efficacy, functionality and feature set. Other DVT therapy devices do not deliver the same clinical efficacy and treatment options for my patient. As a result dispense as written my prescription for this patient and do not substitute this order for my patient.

Prescriber Signature: **Date:**

Prescriber Printed Name: **NPI:**

Address:

City: **State:** **Zip:**