

Self-Testing Referral Form/RX and Letter of Medical Necessity

New Prescription
 Prescription Renewal
 Physician Change

Patient information (Name, DOB, Phone # required)	
Patient Name:	Patient Phone #:
Date of Birth (mm/dd/yyyy):	Patient Secondary #:
Address:	Contact Person:
	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	PHM has permission to leave messages: <input type="checkbox"/> Yes <input type="checkbox"/> No
Warfarin & Meter Information (90 days and INR Range required)	
Patient has been on warfarin > 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No, patient started on	
Test Frequency: Weekly	Target INR Range: ___ (low) to ___ (high)
Reporting Preference:	<input type="checkbox"/> Weekly reports (one report for each test) <input type="checkbox"/> Monthly summaries (first of the month)
ICD-9/ICD-10 Diagnosis (At least one diagnosis required)	
V43.3 Heart valve replaced by other means (Mechanical Heart Valve)	
<input type="checkbox"/> Z95.2 Presence of prosthetic heart valve	
427.31 Atrial Fibrillation <input type="checkbox"/> I48.0 Paroxysmal Atrial Fibrillation <input type="checkbox"/> I48.1 Persistent Atrial Fibrillation <input type="checkbox"/> I48.2 Chronic Atrial Fibrillation <input type="checkbox"/> I48.91 Unspecified Atrial Fibrillation	415.11 - 415.19 Pulmonary Embolism <input type="checkbox"/> I26.01 Septic pulmonary embolism with acute cor pulmonale <input type="checkbox"/> I26.09 Other pulmonary embolism with acute cor pulmonale <input type="checkbox"/> I26.90 Septic pulmonary embolism without acute cor pulmonale <input type="checkbox"/> I26.99 Other pulmonary embolism without acute cor pulmonale
453.40-453.42 Acute venous embolism and thrombosis, unspecified deep vessels, lower extremity (DVT) <input type="checkbox"/> I82.401 unspecified deep veins, right lower extremity <input type="checkbox"/> I82.402 unspecified deep veins, left lower extremity <input type="checkbox"/> I82.403 unspecified deep veins, lower extremity, bilateral <input type="checkbox"/> I82.409 unspecified deep veins, unspecified lower extremity	453.82-453.89 Acute venous embolism and thrombosis, deep veins, upper extremity (DVT) <input type="checkbox"/> I82.621 deep veins, right upper extremity <input type="checkbox"/> I82.622 deep veins, left upper extremity <input type="checkbox"/> I82.623 deep veins, upper extremity, bilateral <input type="checkbox"/> I82.629 deep veins, unspecified upper extremity
453.9 Embolism and thrombosis of unspecified site	
<input type="checkbox"/> I82.91 Chronic embolism and thrombosis of unspecified vein	
Physician/Group Information (Physician Name, Phone #, Fax # required)	
Prescribing Physician:	Phone:
Group Practice/Hospital:	Fax:
Contact:	Address:
NPI#:	City/State/Zip :
Statement of Medical Necessity/Prescription (Signature required)	
<p>Patient requires anticoagulation treatment/therapy to reduce the risk of Thromboembolism. If the patient is not properly anticoagulated, the patient may experience adverse events such as a stroke, clot formation, bleeding or myocardial injury. Patient self-testing is a service that requires the patient or the patient's caregiver to administer a PT/INR test and report the results on a weekly basis to Patient Home Monitoring (PHM) for the duration of this patient's anticoagulation therapy.</p> <p>I certify that this patient has been on warfarin for ≥ 90 days and will receive the training to ensure that the patient or the patient's caregiver is able to perform a PT/INR test, understand results, communicate these results to a PHM case manager weekly and make the necessary adjustments to their on-going therapy as directed.</p> <p>I agree to notify PHM if the patient or their caregiver develops a condition that makes PT/INR self-testing unsafe.</p>	
Provider Signature	Date

Please fax completed form to Patient Home Monitoring at (415) 800-6052

Patient Home Monitoring
 300 Montgomery Street, Ste 925
 San Francisco, CA 94108