



**OSTOMY ORDER FORM**

Fax Completed Form and Medical Records To: 207-622-3264

Questions: 207-621-0698 ext 214

**PATIENT INFORMATION:**

First Name:	Last Name:	Date of Birth:
Physical Address:		
City:	State:	Zip:
Phone #:	Email:	Mobile:

**INSURANCE INFORMATION:**

Primary Insurance Name:	ID#
Secondary Insurance Name:	ID#

**CLINICAL INFORMATION:**

Start Date:	Length of need = 99 if lifetime unless otherwise indicated: _____
Primary Diag: <input type="checkbox"/> Z93.2 Ileostomy <input type="checkbox"/> Z93.3 Colostomy <input type="checkbox"/> Z93.6 Urostomy <input type="checkbox"/> Other: _____	
Secondary Diag: <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Perforated Bowel <input type="checkbox"/> Bladder Cancer <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Bowel Obstruction <input type="checkbox"/> Other: _____	

**RECOMMENDED SUPPLIES:**

Item: <small>(all limits based on Medicare policy)</small>	Maximum Allowable Per Month	Brand Preference	Product #	Frequency of Use	QTY/MO
One Piece Pouch: <input type="checkbox"/> Drainable <input type="checkbox"/> Closed <input type="checkbox"/> Urostomy	Drain #20—Closed #60				
**Two Piece Pouch: <input type="checkbox"/> Drainable <input type="checkbox"/> Closed <input type="checkbox"/> Urostomy	Drain #20—Closed #60				
**Skin Barrier with Flange (required with two-piece pouch)	20				
Skin Barrier Wipes No-Sting (25 allowed per month)	25				
Adhesive Remover Wipes No-Sting (25 allowed per month)	25				
Barrier Rings: (20 allowed per month) <input type="checkbox"/> 2" <input type="checkbox"/> 4"	20				
Lubricating Deodorant (8 oz allowed per month)	8 oz				
Powder: <input type="checkbox"/> Pectin <input type="checkbox"/> Karaya (2 oz allowed per month)	2 oz				
Paste: <input type="checkbox"/> Pectin <input type="checkbox"/> Non Pectin (4 oz allowed per month)	4 oz				
Skin Barrier Strips (20 allowed per month)	20				
Ostomy Belt: <input type="checkbox"/> Med (26-43" hip size) <input type="checkbox"/> Lg (34-65" hip size)	1				
Night Drain Bag: (2 allowed per month) <input type="checkbox"/> Bottle <input type="checkbox"/> Bag 2000cc	2				
Leg Drain Bag: (2 allowed per month)	2				
Additional Items:					
# of Refills Allowed: <input type="checkbox"/> 1 <input type="checkbox"/> 6 <input type="checkbox"/> 11	<b>Medical records required with all new orders and must be the last F2F that has occurred within 6 months of the signed order</b>				

**Licensed Healthcare Provider Acknowledges:** My signature denotes that the statements above are true, accurate and complete, to the best of my knowledge. I certify that the patient is being treated by me and I have seen the patient in the last 6 months. The patient is informed that s/he will be contacted by Community Pharmacy regarding coverage for items ordered. I authorize the prescription of the supplies above.

\_\_\_\_\_  
*Signature of Physician, Nurse Practitioner, Physician Assistant* \_\_\_\_\_  
*Printed Name of Physician, Nurse Practitioner, Physician Assistant*

NPI: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_