INTERMITTENT CATHETER

RX Form

TRICARE® MMS MILITARY MEDICAL SUPPLIES
Serving Those Who Serve America

Email to: info@militarymedical.us.com **Fax to:** (800) 497-8856

ALL FIELDS REQUIRED

PATIENT INFO

Patient Name: _____ Order Date: _____

☐ Chart Notes Attached (Chart notes must include the need for the supplies ordered) ☐ Face Sheet/Demographics Faxed

Gender: ☐ Male ☐ Female Patient DOB: _____

Insurance: _____ Member ID#: _____

DIAGNOSIS (Check appropriate diagnosis below)

☐ R33.9 - Urinary Retention

☐ R32 - Urinary Incontinence

☐ N31.9 - Neurogenic Bladder

☐ Other Primary Diagnosis: _____

Secondary Diagnosis: _____

DURATION OF NEED _____ months

(1-99 months; 99=Lifetime)

NUMBER REFILLS _____

Latex Allergy: ☐ Yes ☐ No

UTI History: ☐ Yes ☐ No

(If yes to UTI, please fax a copy of lab work and/or supporting documentation with this form).

CATHETER PRODUCT TYPES (HCPCS)

☐ Straight-Tip Catheter (A4351)

☐ Sterile Catheter w/ Insertion Supplies (A4353)

☐ Coude-Tip Catheter (A4352) supporting DX needed

Supporting DX for Coude:

☐ N40 - BPH ☐ N32 - Bladder Neck Obstruction ☐ Other _____

FRENCH SIZE

☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 16 ☐ 18 Other: _____

☐ **DISPENSE AS WRITTEN OR/**
☐ **PRODUCT SELECTION PERMITTED**

_____

FREQUENCY

☐ 2 per day/60 per month/180 per 3 months

☐ 3 per day/90 per month/270 per 3 months

☐ 4 per day/120 per month/360 per 3 months

☐ 5 per day/150 per month/450 per 3 months

☐ 6 per day/180 per month/540 per 3 months

☐ Other _____ per day _____ per month _____ per 3 months

OTHER PRODUCT TYPES

☐ Lubricant Packets 3 gm (A4332) one packet per cath _____

Tube, 4 oz (A4402) _____ quantity _____

☐ Other: _____ ☐ Quantity Per Month: _____

PRESCRIBING PHYSICIAN INFORMATION

Name: _____

Phone: _____ Fax: _____

Clinic: _____ NPI: _____

Signature: _____ Signature Date: _____

(Stamped signature not accepted)

☐ I certify that this order is reasonable and medically necessary or it is a mandated benefit. This document may serve as confirmation of a verbal order and is also written in the patient's record. The information provided is true, accurate and complete. I will retain a copy in the patient's chart.

UROLOGY

Detailed Written Order

Email to: info@militarymedical.us.com **Fax to:** (800) 497-8856

If filled out completely, this form serves as the Detailed Written Order (DWO) and proof that patient was seen by the physician within 6 months prior to the date of order. This must be received by supplier before equipment is dispensed.

INTERMITTENT CATHETERIZATION

Intermittent catheterization is covered when basic coverage criteria are met and the beneficiary or caregiver can perform the procedure.

A. For each episode of covered catheterization Tricare will cover:

B. One catheter (A4351, A4352) and an individual packet of lubricant (A4332); or

One sterile intermittent catheter kit (A4353) if additional coverage criteria (see below) are met.
Intermittent catheterization using a sterile intermittent catheter kit (A4353) is covered when the beneficiary requires catheterization and the beneficiary meets one of the following criteria (1-5):

1. The beneficiary resides in a nursing facility,
2. The beneficiary is immunosuppressed, for example (not all-inclusive):
   - on a regimen of immunosuppressive drugs post-transplant,
   - on cancer chemotherapy,
   - has AIDS,
   - has a drug-induced state such as chronic oral corticosteroid use,
3. The beneficiary has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization,
4. The beneficiary is a spinal cord injured female with neurogenic bladder who is pregnant (for duration of pregnancy only),
5. The beneficiary has had distinct, recurrent urinary tract infections, while on a program of sterile intermittent catheterization with A4351/A4352 and sterile lubricant A4332, twice within the 12-month prior to the initiation of sterile intermittent catheter kits.

A beneficiary would be considered to have a urinary tract infection if they have a urine culture with greater than 10,000 colony forming units of a urinary pathogen AND concurrent presence of one or more of the following signs, symptoms or laboratory findings:

- Fever (oral temperature greater than 38° C [100.4° F])
- Systemic leukocytosis
- Change in urinary urgency, frequency, or incontinence
- Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation)
- Physical signs of prostatitis, epididymitis, orchitis
- Increased muscle spasms
- Pyuria (greater than 5 white blood cells [WBCs] per high- powered field)

Usual Maximum of Supplies Code

Supplies Code	Number per Month
A4332	200
A4351	200
A4352	200
A4353	200

Use of a Coude (curved) tip catheter (A4352) in female beneficiaries is rarely reasonable and necessary. When a Coude tip catheter is used (either male or female beneficiaries) there must be documentation in the beneficiary's medical record of the medical necessity for that catheter. An example would be the inability to catheterize with a straight tip catheter. This documentation must be available upon request. If documentation is requested and does not substantiate medical necessity, claims will be denied as not reasonable and necessary.

Tricare requires that it is a physician (MD, DO, or DPM), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) perform the office visit examination with the beneficiary. The chart note from the office visit exam must be signed and dated by the author of the note. If completed by a PA, NP, or CNS, the physician (MD, DO or DPM) must cosign and date the note.

BRANCHES:

California:
P: (800) 270-6990
F: (800) 497-8856
NPI # 1942392527

Arizona:
P: (623) 248-1630
F: (623) 248-1701
NPI # 1366008161

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P: (719) 413-5090
F: (719) 413-5089
NPI # 1174137731

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F: (253) 344-1457
NPI # 1669040465

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F: (888) 286-7412
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