Phothera®
Embrace Life with Confidence

MAYO CLINIC

Physician Written Order for Home Phototherapy

Fax to Phothera: 216.765.0271 This form is a prescription and statement of medical necessity for Phothera home phototherapy devices only. (For refills or replacement lamp prescriptions, please contact us at support.phothera.com) All fields are required for insurance approval. Missing information or incomplete forms may result in delays in processing.

* **Provider Note** Please include a copy of the patient's insurance card and chart notes with this prescription for processing. ☐ Insurance Card (Front & Back) ☐ Chart Notes

PATIENT INFO

First Name _____ Last Name _____ DOB _____ Gender ☐ M ☐ F ☐ Other

Address _____ City _____ State _____ Zip _____

Mobile Phone # _____ Alt Phone # or Email _____

Primary Policy Holder Name _____ Primary Policy Holder DOB _____

Insurance Plan _____ Policy/Member ID # _____

PROVIDER

Provider Name _____ Title _____ NPI _____ Practice _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ Provider Email _____

HOME PHOTOTHERAPY PRODUCT

1 Time Only Product Selection

(mm:ss) Time-only mode lets you run a phototherapy session for a fixed amount of time. The patient enters the treatment duration (i.e., 0 minutes 12 seconds or 0:12), and the device stays on for exactly that long. Dose - Time conversion calculators are available here: https://www.phothera.com/

HCPCs	Product & Description
E0691	☐ **Phothera 100 or 100XL** Hand-held treatment wand for scalp, spot treatment or travel. Includes comb attachment.

Guided Mode Product Selection

LITE STUDY

Fewest steps to prescribe. Safe for all skin types.

Safest and easiest mode for patients. Utilized in a randomized clinical trial (LITE Study) published in JAMA demonstrating enhanced patient adherence rates and safety outcomes. Guided Mode takes the patient safely through every treatment.

HCPCs	Product & Description
E0691	☐ **Phothera 200** Small, light-weight panel (2 sq. ft.) for hands, face, feet, elbows, or other localized treatment areas.
E0694	☐ **Phothera 600-3D** 6 ft. tall panel for large areas of body surface or full body treatments. Easiest to achieve wide-spread coverage.
_____	☐ **Other:** _____

TREATMENT DETAILS

2 Skin Type Must be selected if utilizing Guided Mode (GM)

If unsure, choose **I/II** as it is the safest for all skin types.

- ☐ **I/II** (GM starting dose: 200 mJ with 15% subsequent increases)
- ☐ **III/IV** (GM starting dose: 400 mJ with 15% subsequent increases)
- ☐ **V/VI** (GM starting dose: 600 mJ with 15% subsequent increases)

Prescribed Lamp Type (Guided Mode defaults lamp type to NB-UVB.)

☐ NB-UVB ☐ Other: _____

Available Exposures

☐ 250 ☐ Unlimited

DIAGNOSIS

3 Diagnosis ICD-10 Code Must Be Indicated

ICD-10 Code	Description
L20 . _____	☐ Other Atopic Dermatitis
L40 . _____	☐ Psoriasis: _____
L80	☐ Vitiligo
C84. _____	☐ CTCL: _____
___ . _____	☐ Other: _____

STATEMENT OF MEDICAL NECESSITY (Required for Insurance Approval)

4 Estimated Duration of Need (99 = Lifetime)

☐ 99 Months ☐ Other: _____

BSA (Body Surface Area) & Severity Please check all that apply.

Percentages are totaled to calculate the severity level.

☐ Hands	2%	☐ Chest / Abdomen	18%	**Total BSA:**
☐ Feet	2%	☐ Arms	18%	_____ %
☐ Scalp	9%	☐ Legs	18%	
☐ Back	18%	☐ Other: _____ %		

Previous Treatments Please list. _____

_____

_____

Was it effective? ..... Yes ☐ No ☐

Is the condition chronic? ..... Yes ☐ No ☐

Has the patient had in-office UV light therapy? ..... Yes ☐ No ☐

If yes, did the patient benefit from it? ..... Yes ☐ No ☐

Is the patient and/or caregiver reliable, motivated, and able to adhere to instructions? ..... Yes ☐ No ☐

Reason for Home Use Please check all that apply.

- ☐ Therapy is considered long-term
- ☐ Drugs or topicals are contraindicated or too expensive
- ☐ Distance and travel time to office
- ☐ Co-pay cost of frequent in-office visits
- ☐ Unable to take time away from work or school
- ☐ Other: _____

I certify that I am the physician identified on this form. I have reviewed this Physician's Written Order. Any statement on my letterhead attached hereto has also been reviewed and signed by me. I certify that this patient and/or caregiver is capable and will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the product listed, and the physician notes and other supporting documentation will be provided upon request. I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Provider Signature _____ Date _____

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