PHYSICIAN FORM – ProTime®

TAPESTRY MEDICAL
6465 National Drive, Livermore, California 94550
www.**COAGNOW**.com
(1-877-262-4669, option 1) with any questions.

Exemplary Provider® awarded by Medicare deeming authority

FAX COMPLETED FORM TO **1-925-606-6978** OR **1-925-605-3837**

1. Patient & Physician Information

PATIENT NAME: (Last Name, First , Middle Initial)	**DATE OF BIRTH:** (mm/dd/yyyy) / /	**GENDER:** ☐ Female ☐ Male
PRESCRIBING PHYSICIAN:	**LICENSE #:**	**NPI #:**
GROUP PRACTICE OR HOSPITAL NAME:	**OFFICE PHONE:** ( )	**OFFICE FAX:** ( )
MAILING ADDRESS: (Street)	**CITY:**	**STATE:** / **ZIP CODE:**

REPORT RESULTS TO: (Only if different from above)

CONTACT NAME:	**CONTACT PHONE:** ( )	**CONTACT FAX:** ( )

AFTER HOURS CONTACT INSTRUCTIONS:

2. Statement of Medical Necessity / Prescription

Patient should receive Home INR Monitoring (GO248/GO249) services to enable him/her to self-test according to my instructions provided below. I believe that it is medically necessary for patient to self-test frequently in order to maintain a stable INR, optimize its therapeutic effects and avoid the complications identified on warfarin's product labeling.

I certify that this **patient has been on warfarin therapy for >90 days** and will undergo a training program provided by Tapestry Medical to ensure that he/she is capable of self-testing. At this time, the patient or their caregiver has no condition that makes self-testing unsafe (e.g. cognitive disorders). Patient should continue in Tapestry Medical's Home INR Monitoring Program for as long as he/she remains capable and compliant with my instructions. In the future, I agree to notify Tapestry Medical if the patient or their caregiver develops a condition that makes self testing unsafe. Patient should be enrolled in this program for a **minimum of one year**.

PATIENT'S DIAGNOSIS	**ICD-9-CM CODE:**	**COMPLICATIONS:**	**COMORBIDITIES:**
☐ Organ or tissue replaced by other means; heart valve	V43.3	☐ Long term Anticoagulant Use	☐ Diabetes
☐ Atrial fibrillation (established) (paroxysmal)	427.31	☐ Potential drug/dietary interactions	☐ CHF
☐ Venous embolism & thrombosis	453.0-453.3, 453.40-453.42, 453.8-453.9	☐ Venipuncture difficulty	☐ COPD
☐ Phlebitis & thrombophlebitis	451.0 – 451.9	☐ History TIA/Stroke	☐ Thyroid Disorder
☐ Pulmonary embolism & infarction	415.11 – 415.19	☐ History of unstable INR	☐ Other:
☐ Primary hypercoagulable state	289.81	☐ History of major bleeding	
☐ Other:		☐ Other:	
Warfarin Start date: / /		☐ Recent Hospitalizations: / /	

3. Target INR Range & Test Frequency

TARGET INR RANGE: _____ (LOW) **TO** _____ (HIGH)

TEST FREQUENCY: ☐ Weekly* ☐ 2-4 times/month ☐ Other: _____

*Medicare will cover up to 52 tests per year.

TEST REPORTING INSTRUCTIONS: *(Please select either option* **A** *or* **B***)*

A ☐ **Direct to Physician Office**

Patient will communicate test results directly to my office. Patient will also provide TMI with all past test results at least once a month to ensure ongoing test supplies.

NOTE: Documenting home INR test results is required by Medicare and other payors in order for Patient's testing supplies (G0249) to be covered. TMI will provide a report of past results as a courtesy to support Physician claims for Review and Interpretation of home INR tests (G0250).

B ☐ **Direct to Tapestry Medical (TMI)** Instructions as follows:

If Patient obtains an INR result outside of the Target Range then:

DO NOT MARK boxes at right if you chose option A.

- ☐ TMI should contact my office immediately.
- ☐ TMI should instruct Patient to retest within _____ days.
- ☐ TMI will notify my office via fax/phone immediately when PT/INR result is out of range. Otherwise fax monthly report.
- ☐ Other: _____

Patient will communicate test results directly to TMI who will report INR test results to me according to my instructions above.

NOTE: If Patient reports an INR value <1.5 or >5.0, then TMI will make direct contact with your office. If TMI is unable to communicate with a qualified individual from your office, then TMI will recommend to your Patient to seek immediate emergency care.

ITEMS PRESCRIBED: ProTime Microcoagulation System & Supplies

PHYSICIAN'S SIGNATURE:	**DATE:** (mm/dd/yyy)	**PATIENT TRAINING PREFERENCE?** ☐ Yes ☐ No

DO NOT SUBSTITUTE

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