Health Plan of San Mateo
Incontinence Supplies Prescription Form

This form must accompany all *Treatment Authorization Requests* (TARs) for incontinence supplies. The prescription form must include all supplies needed for the time period, not just the supplies requiring a TAR. This form must be completed in its entirety.

Recipient Name: ______________________ Date of Birth: ______________________
Medi-Cal ID Number: ______________________ Age: ______________________

Height: ______________ Weight: ______________

Recipient Residence: ☐ Home ☐ Board and Care ☐ ICF/DD-H ☐ ICF/DD-N

☐ Other ______________________

Provider Contact: ______________________
Telephone Number: ______________________

1. Recipient is incontinent of: ☐ Bowel ☐ Bladder

2. Status: ☐ Temporary ☐ Permanent

3. Medical condition/diagnosis causing bowel or bladder incontinence, include primary ICD-9 code (condition causing incontinence) and secondary ICD-9 code (type of incontinence), (Include both diagnosis codes on authorization form):

____
____

4. Type of urinary incontinence: ☐ Overflow ☐ Stress ☐ Urge
☐ ☐ Mixed ☐ Functional

5. Type of bowel incontinence: ☐ Nervous system pathology
☐ Functional (for example, chronic constipation)

6. Describe any previous evaluation and treatments attempted and outcomes. Document reasons why other treatment options (pharmacologic, drug, behavioral techniques or surgical intervention) are not appropriate to decrease or eliminate incontinence:

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____

7. Prognosis for controlling incontinence:

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8. Brief summary of incontinence therapeutic intervention or treatment plan:

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9. Document need for and usage of multiple absorbent products and garments or need for quantities exceeding Medi-Cal formulary allowable amounts. Explain need if requesting multiple types of incontinence supplies:

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____

10. Medi-Cal formulary items tried and/or failed, include reason(s) and formulary item codes or description:

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Mark a "T" in the "Needs TAR?" column if the supply needs a TAR.

NEEDS TAR?	PRODUCT TYPE AND BILLING CODE	DAILY USAGE	UNIT COST	MONTHLY USAGE	MONTHLY COST (Includes Markup and Sales Tax)	TOTAL UNITS	TOTAL COSTS (Includes Markup and Sales Tax)

Prescription valid for _________ months.

Prescribing Physician's Verification (Physician Use Only)

I have reviewed my patient's medical records and the items requested above. I verify that I have physically examined the patient within the last 12 months and have established that this patient has a chronic pathologic condition which is causally related to his/her incontinence and that other treatment options are not appropriate to decrease or eliminate incontinence. I have prescribed the items described above which I have determined to be medically necessary for this patient. I will maintain a copy of this prescription in the recipient's medical record to meet HPSM documentation requirements.

Physician's Name and Address (please print or type):

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Physician's Telephone No.: ________________________ Physician's NPI: ________________________

Physician's Signature: ________________________ Date: ________________________