DME Prescription Order Form & Letter of Medical Necessity

Form must be manually signed then faxed to (818) 775-2941

RA FISCHER CO.
Ph: (800)525-3467 Fax: (818)775-2941
www.rafischer.com

Patient Information

Please Attach History and Chart Notes *Additional documentation may be requested to document medical necessity.*

Patient Name	DOB	Member ID		
Street Address	City	State	ZIP	
Phone Number	Email			

Equipment Information

Equipment Needed	Diagnosis	Length of Need
☑ E1399 | The Fischer: Metal-Free Iontophoresis Device ☐ Hands and Feet ☐ Underarms ☐ Hands, Feet, and Underarms	☐ L74.512 Palmar Hyperhidrosis ☐ L74.513 Plantar Hyperhidrosis ☐ L74.510 Axilla Hyperhidrosis ☐ R.61 Generalized Hyperhidrosis	☑ 99 (in months = lifetime)

Letter of Medical Necessity

I am writing on behalf of my patient to document the medical necessity of a Fischer Iontophoresis device for the treatment of hyperhidrosis. This letter provides information about the patient's medical history and diagnosis and a statement summarizing my treatment rationale. Hyperhidrosis, or excessive sweating, can have a devastating effect on a patient's quality of life, causing physical discomfort, social embarrassment, and disruption of occupational and daily activities. This has certainly been true for the above patient who has been severely impacted by hyperhidrosis. The patient has also experienced the following (check all that apply):

☐ Extreme anxiety related to the condition_____

☐ Secondary medical conditions such as dermatitis, eczema, or infection_____

☐ Occupational handicap and functional impairment_____

Iontophoresis, as a treatment method, has shown promising results in addressing hyperhidrosis. The Fischer Iontophoresis device, specifically designed for self-treatment of the hands, feet, and/or underarms, offers an effective and economical solution for managing this condition. The treatment involves the use of the Fischer device, which generates a direct current (DC) applied to the affected areas. This process leads to the development of hyperkeratotic plugs within the sweat ducts, resulting in poral closure and a reduction in sweating. However, as the reduction is temporary, ongoing retreatment at one to three-week intervals is necessary to maintain the desired effect.

Alternative treatment options, such as BOTOX® injections and surgery (sympathectomy), have been considered but deemed less favorable due to their associated side effects. These side effects include Horner's syndrome, compensatory hyperhidrosis, and gustatory sweating. Considering the potential risks and complications of these alternatives, the Fischer Iontophoresis device emerges as a safer and more appropriate treatment choice for the patient. Hyperhidrosis is a chronic condition, and while some improvement may occur later in life, the need for an effective treatment device like the Fischer Iontophoresis device remains indefinite. The patient's quality of life and overall well-being would significantly benefit from the availability and coverage of this device.

In conclusion, based on my evaluation of the patient's medical history and the limited success and potential risks associated with other treatment options, I strongly recommend the coverage of a Fischer Iontophoresis device for the treatment of hyperhidrosis. The patient's specific circumstances, including [Patient's duration and severity of the condition, previous treatments attempted, and their outcomes], warrant the use of this device. Furthermore, given the nature of hyperhidrosis and the lack of in-network providers available to provide this iontophoresis device, in-network coverage is justified to ensure timely access to this medically necessary treatment.

Physician Information

Physician Name	NPI	Tax ID		
Office Name	Street Address	City	State	ZIP
Phone Number	Fax	Signature		

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For more information about hyperhidrosis, visit the RA Fischer Company at www.rafischer.com

Hyperhidrosis Prior Authorization Request Form

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Patient Information

Patient Name	DOB	Member ID

Equipment Information

Equipment Name

☑ E1399 | **The Fischer**: Metal-Free Iontophoresis Device for the treatment of hyperhidrosis for lifetime use

Diagnosis

- ☐ L74.512 Palmar Hyperhidrosis
- ☐ L74.513 Plantar Hyperhidrosis
- ☐ L74.510 Axilla Hyperhidrosis
- ☐ R61 Generalized Hyperhidrosis

History & Previous Treatments

› What areas of the body require treatment?

- ☐ Axillary (Underarms)
- ☐ Palmar (Hands)
- ☐ Plantar (Feet)
- ☐ Craniofacial
- ☐ Sub Mammary
- ☐ Other: _____

› Hyperhidrosis Disease Severity Scale - Select which severity level applies to you:

- ☐ Sweating is **never** noticeable and **never** interferes with daily activities.
- ☐ Sweating is **tolerable** and **sometimes** interferes with daily activities.
- ☐ Sweating is **barely** tolerable and **frequently** interferes with daily activities.
- ☐ Sweating is **intolerable** and **always** interferes with daily activities.

› Impairment of Daily Activities, & Impact on Quality of Life:

- ☐ Work & professional life
- ☐ Meeting new people
- ☐ Relationships with others
- ☐ Shaking hands
- ☐ Developing personal relationships
- ☐ Sexual Activities
- ☐ Sports
- ☐ Clothing/Shoes
- ☐ Emotional State
- ☐ Education
- ☐ Other: _____ _____

› Previous Treatments

- ☐ OTC Antiperspirants
- ☐ Oral Medications (Robinul, Glycopyrrolate)
- ☐ RX Antiperspirants (Drysol™)
- ☐ Surgery (ETS)
- ☐ Iontophoresis (In-Office - CPT: 97033)
- ☐ miraDry®
- ☐ Botox®
- ☐ Other: _____

› Notes

_____

_____

_____

Please Attach History and Chart Notes

Additional documentation may be requested to document medical necessity.

Physician Information

_____ *Initial*

I certify that the patient's daily life has been severely impacted by hyperhidrosis. From their inability to perform normal daily tasks, to the mental and physical stress of living with extreme sweating, hyperhidrosis has affected this patient's quality of life.

Physician Name	NPI	Signature

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Iontophoresis Insurance Packet

Form must be manually signed then faxed to (818) 775-2941

Dear Provider, Please submit the following information to us to obtain insurance coverage for a Fischer Iontophoresis device for your patient.	Via email: info@rafischer.com Via fax: (818) 775-2941

Patient Information

Please Attach History and Chart Notes *Additional documentation may be requested to document medical necessity.*

Patient Name		DOB	
Street Address	City	State	ZIP
Phone Number	Email		

Insurance Information

Please Attach Copy of Insurance Card

Plan Name	Member ID
Policy Holder Name	Policy Holder DOB

Authorization to Assign Benefits to the Provider and Release of Medical Information

Authorization to assign benefits to the Provider and Release of Medical Information: I request that payment of authorized benefits be made on my behalf to AR Hinkel Co, Inc./RA Fischer Co. and affiliates for products or services that they may have provided me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical related information about me to be released to the Health Care Finance Administration or other health care coverage entity, any information for this or any related health care claim in writing or verbally. I also authorize my insurance company(ies) to furnish to an agent of AR Hinkel Co, Inc./RA Fischer Co. and affiliates any and all information pertaining to my insurance benefits and status of claims submitted by AR Hinkel Co, Inc./RA Fischer Co. and affiliates for services rendered. I further authorize AR Hinkel Co, Inc./RA Fischer Co. and affiliates to release to my insurance company(ies) any and all information pertaining to me for benefit determination.

I understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary.

If someone other than the patient is signing this authorization, please state the relationship with patient and the reason patient is unable to sign.

_____
Signature of Patient/Authorized Representative

_____
Name of Authorized Representative (if applicable)

_____
Authorized Representative Relationship to Patient

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