Lake Region HOME MEDICAL SUPPLY

Physician's Order for External Infusion Pump

Acct: _____

Date of Order: _____

Patient Name: _____ DOB: _____

Date of In-Person visit with Physician: _____ *(must be within 6 months prior to order)*

Diagnosis Code(s) supporting need: _____

- Medicare will cover an infusion pump for administration of chemotherapy for the treatment of primary hepatocellular carcinoma or colorectal cancer where this disease is unresectable, or where the patient refuses surgical excision of the tumor. Medicare patients must be re-evaluated by the treating physician at least every 3 months.
- Other insurance plans may not limit the diagnosis to the above.

Drug to be administered: _____

Route of Administration: ☐ Intravenous ☐ Subcutaneous ☐ Epidural ☐ Other _____

Method of Administration: ☐ Continuous ☐ Intermittent

Physician Order

Start Date (if different from Date of Order): _____

Length of Need: ☐ 12 months ☐ Lifetime ☐ Other: _____

Equipment:

☐ Ambulatory Infusion Pump (E0781)
☐ Medication Cassette (A4222) 60 per month
☐ Extension Set with Luer Lock (A4221) 4 per month
☐ Other _____

Physician Signature: _____ **Date:** _____

Physician Name: (please print) _____ **NPI:** _____

******Please attach copy of signed progress note from in-person visit with physician******

Fax back to: 320-231-4941