Vacuum Assisted Wound Closure Device Request Form

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Member ID:</th>
</tr>
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<tbody>
<tr>
<td>Requesting Physician:</td>
<td>Contact Name:</td>
</tr>
<tr>
<td>Phone Number:</td>
<td>Fax Number:</td>
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</tbody>
</table>

The member named above has requested coverage for Vacuum Assisted Wound Closure Device.

BCBSNC will provide coverage for a Vacuum Assisted Wound Closure Device when the criteria shown below are met in accordance with BCBSNC Vacuum Assisted Closure of Wounds Medical Policy http://www.bcbsnc.com/services/medical-policy/pdf/vacuum_assisted_closure_of_wounds.pdf

**INITIAL APPROVAL:**
Please complete Part A below for chronic wounds, or Part B below for acute or subacute wounds.

**Part A** [complete for chronic wounds, including information for the specific type of chronic wound under subsection (1) or (2) or (3)]

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Does the patient have a chronic wound present for over 30 days that has failed standard therapy?</td>
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<tr>
<td>- Is management with a complete wound therapy program documented in the medical records?</td>
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<tr>
<td>- Has there been application of dressing to maintain a moist wound environment?</td>
<td></td>
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<td>- Has necrotic tissue been debrided, if present?</td>
<td></td>
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<tr>
<td>(check here if not applicable ☐)</td>
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<td></td>
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<tr>
<td>- Is nutritional status adequate to promote wound healing?</td>
<td></td>
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<td>- Has the patient been compliant with the wound therapy program?</td>
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AND

(1) For Stage III or IV pressure ulcers (must meet all three criteria):

- Has the patient been appropriately turned and positioned? ☐ ☐
- Has the patient used a group 2 or 3 pressure reducing support surface on the posterior trunk or pelvis?
  Specify type used: __________________________
- Have the patient’s moisture and incontinence been appropriately managed? ☐ ☐

OR

(2) For neuropathic (e.g., diabetic) ulcers (must meet both criteria):

- Has the patient been treated with a comprehensive diabetic management program? ☐ ☐
- Has reduction in pressure on foot ulcer been accomplished? ☐ ☐

OR

(3) For venous insufficiency ulcers (must meet both criteria):

- Have compression bandages and/or garments been consistently applied? ☐ ☐
- Have leg elevation and ambulation been encouraged? ☐ ☐
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Part B [complete for acute or subacute wounds]

- Does the patient have complications of a surgically created wound? □ □
  If YES, does patient have any of the following:
  ▪ Post-sternotomy disunion with exposed bone? □ □
  ▪ Post-sternotomy mediastinitis? □ □
  ▪ Flap or graft failure? □ □
  ▪ Wound dehiscence? □ □
  ▪ Other? (Specify) ________________________________

- Does the patient have a traumatic wound that will require a flap or graft? □ □
  (e.g. degloving injury, high-energy soft tissue injury, wound exposing tendon, bone, and/or joint)
- Does the patient have a co-morbidity that is expected to significantly prolong wound healing? □ □
  If YES please specify:
  ▪ Diabetes? □ □
  ▪ Renal disease (e.g. chronic kidney disease or ESRD)? □ □
  ▪ Ischemic vascular disease? □ □
  ▪ Other? (Specify) ________________________________

- Is the primary intent of the Vacuum Assisted Wound Closure Device use to speed wound healing when normal healing would otherwise be expected? □ □

Date of most recent wound measurements: __________________
Length: _____________      Width: ______________      Depth: _______________

If the above BCBSNC Medical Policy criteria are met, coverage for a Vacuum Assisted Wound Closure Device will be approved for an initial period of 14 days.

BCBSNC does not provide coverage for a Vacuum Assisted Wound Closure Device:
♦ When the above criteria are not met.

By my signature below, I certify that the information on this form accurately reflects the content of my medical records. I agree to submit medical records to BCBSNC for review upon request.

Physician signature: ___________________________ Date: ___________________

Fax completed form to 1-800-228-0838