REAL TIME DIAGNOSTICS
PT/INR HOME TESTING

PRESCRIPTION FOR:
PT/INR Patient Self-Testing

4 Easy Steps to Get Started!

1. Complete Patient Information
2. Complete Statement of Medical Necessity/Prescription
3. Select Target Range, Test Frequency and Reporting Options
4. Complete Physician Information and Sign and Date

Fax completed form to 1-877-439-2734.

Feel free to call us at 1-866-662-7897 with any questions.

1. Patient Information

Date: _____/_____/_____ Referred by: _____ AM:_____

Patient Name: _____ ❑ Male ❑ Female

Address: _____

City: _____ State: _____ Zip: _____ Birth Date: _____/_____/_____

Day Phone: (_____)_____ Home Phone: (_____)_____ SS # _____-_____-_____

INSURANCE:

Primary Insurance: ❑ Medicare ❑ BC/BS ❑ Medicaid ❑ Other _____

Contract/Policy # _____ Group # _____ Subscriber: _____

Secondary Insurance: ❑ BC/BS ❑ Medicaid ❑ Other _____

Contract/Policy # _____ Group # _____ Subscriber: _____

2. Statement of Medical Necessity/Prescription

Patient should receive Home INR Monitoring (G0248/G0249) services and supplies 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 weekly in order to maintain a stable INR, optimize its therapeutic effects and avoid the complications identified on Coumadin® (warfarin)'s product labeling.

I certify that this patient has been on Coumadin® (warfarin) therapy for more than 90 days and will undergo a training program provided by Real-Time Diagnostics (RTD) to ensure that he/she is capable of self-testing. At this time, if the patient or their caregiver has no condition that makes self-testing unsafe (e.g. cognitive disorders), patient should continue in RTD'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 RTD 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*
❑ Organ or tissue replaced by other means; heart valve	V43.3
❑ Primary hypercoagulable state	289.81
❑ Phlebitis & thrombophlebitis	451.0-451.9
❑ Other venous embolism & thrombosis	453.0-453.3
❑ Pulmonary embolism & infarction	415.11-415.19
❑ Atrial fibrillation (established)(paroxysmal)	427.31

COMPLICATIONS & AGGRAVATING CIRCUMSTANCES:

- ❑ Long term anticoagulant use
- ❑ Potential drug/dietary interactions
- ❑ Venipuncture difficulty
- ❑ History TIA/stroke
- ❑ History of unstable INR
- ❑ History of major bleeding
- ❑ Other: _____
- ❑ Recent Hospitalizations: *Last Date Admitted:* ___/___/____

COMORBIDITIES:

- ❑ Diabetes
- ❑ CHF
- ❑ COPD
- ❑ Thyroid Disorder
- ❑ Other: _____

3. Target INR Range, Test Frequency & Reporting Options

TARGET INR RANGE: _____ (LOW) to _____ (HIGH)

TEST FREQUENCY: ❑ Weekly*

*Medicare will cover up to 52 tests per year.

TEST REPORTING INSTRUCTIONS:

Patient will communicate test results directly to RTD who will report INR test results to me according to my instructions below.

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

- ❑ RTD should contact my office immediately
- ❑ RTD should instruct patient to retest within _____ days
- ❑ Other: _____

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

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

4. Physician Information

Prescribing Physician Name: _____ Date: _____/_____/_____

Physician Signature: _____ NPI No.: _____

Address: _____ License No.: _____

_____ Phone: (_____)_____

_____ Fax: (_____)_____