Atos

PRESCRIPTION FORM

For Laryngectomy Supplies and/or Communication Equipment

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PATIENT INFO

PATIENT REQUIRED INFORMATION

PATIENT FIRST NAME*	PATIENT LAST NAME*	ICD-10 DIAGNOSIS CODE* (CHOOSE ONE): ☐ Z93.0 Tracheostomy Status ☐ Z43.0 Encounter for Attention to Tracheostomy ☐ _____

STREET*	CITY*	ST*	ZIP*	DATE OF BIRTH (MM/DD/YYYY)*

PATIENT TELEPHONE	PATIENT EMAIL	DATE OF SURGERY	☐ MALE ☐ FEMALE

EMERGENCY CONTACT FIRST/LAST NAME	EMERGENCY TELEPHONE	EMERGENCY EMAIL

VOICE REHABILITATION

RX	PROVOX VOICE PROSTHESIS	VOICE PROSTHESIS 1 - CHOOSE ONE SIZE + ONE LENGTH: SIZE (FR)	VOICE PROSTHESIS 1 - CHOOSE ONE SIZE + ONE LENGTH: LENGTH (MM)	VOICE PROSTHESIS 2 - CHOOSE ONE SIZE + ONE LENGTH: SIZE (FR)	VOICE PROSTHESIS 2 - CHOOSE ONE SIZE + ONE LENGTH: LENGTH (MM)	QTY	OTHER
RX	☐ Vega [L8509]	☐ 17 ☐ 20 ☐ 22.5	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15	☐ 17 ☐ 20 ☐ 22.5	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15	1/mo	
RX	☐ Vega XtraSeal [L8509]	☐ 17 ☐ 20 ☐ 22.5	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15	☐ 17 ☐ 20 ☐ 22.5	☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15	1/mo	
RX	☐ Provox2 [L8509]	22.5	☐ 4.5 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15	22.5	☐ 4.5 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5 ☐ 15	1/mo	
RX	☐ ActiValve [L8509]	22.5 ☐ Lt ☐ Strg ☐ XStrg	☐ 4.5 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5	22.5 ☐ Lt ☐ Strg ☐ XStrg	☐ 4.5 ☐ 6 ☐ 8 ☐ 10 ☐ 12.5	1/mo	
RX	☐ NiD [L8507]	☐ 17 ☐ 20	☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 18	☐ 17 ☐ 20	☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 18	1/mo	

RX	PROVOX VOICE PROSTHESIS ACCESSORIES	QTY	OTHER
	☐ Voice Prosthesis Brush OR Flush [L8513]	2/mo	
	☐ Voice Prosthesis Plug [L8511]	1/mo	
	☐ ActiValve Lubricant [A4402]	4oz/mo	

RX	PROVOX VOICE PROSTHESIS ACCESSORIES	QTY	OTHER
RX	☐ Capsule [L8512]: ☐ 17Fr ☐ 20Fr ☐ 22.5Fr	15/mo	
RX	☐ XtraFlange [L8499]: ☐ 17Fr ☐ 20Fr ☐ 22.5Fr	1/mo	
RX	☐ NiD Dilator [L8514]: ☐ 17Fr ☐ 20Fr	1/mo	

▶ For Voice Prosthesis (VP) Accessories, please **INDICATE CURRENT VP TYPE:** _____ **SIZE:** _____ Fr _____ mm

RX	PROVOX SPEECH AIDS	QTY	OTHER
	☐ Electrolarynx [L8500]	1	

RX	PROVOX SPEECH AIDS ACCESSORIES	QTY	OTHER
	☐ Electrolarynx Battery [L8505]	1	

PULMONARY REHABILITATION

RX	PROVOX/PROVOX LIFE ADHESIVES	QTY	OTHER
	☐ Adhesives [A7508]: Any combination of the following Provox Life Adhesives (Standard, Sensitive, Night, Stability) or Provox Adhesives (FlexiDerm, OptiDerm, Luna, StabiliBase, XtraBase) to support situational use.	60/mo	

RX	PROVOX/PROVOX LIFE ATTACHMENTS	QTY	OTHER
RX	☐ LaryTube [A7520]: **SIZE** _____ /_____ **TYPE** ☐ Std ☐ Fen ☐ Rng; **SIZE** _____ /_____ **TYPE** ☐ Std ☐ Fen ☐ Rng. **Provox Life Only** ☐ Fen Rng ☐ Fen Rng	1/mo	
RX	☐ LaryButton [A7524]: **SIZE** _____ /_____ **SIZE** _____ /_____	1/mo	
	☐ LaryClip/TubeHolder/Neckband [A7526]	31/mo	
	☐ HME Cassette Adaptor (Provox Only) [A7503]	1/6mos	
	☐ BasePlate Adaptor [E1399]	1/mo	
RX	☐ BM Tracheostoma Button [A7524]: **SIZE** _____ /_____	1/mo	

RX	PROVOX/PROVOX LIFE HMES	QTY	OTHER
	☐ Heat and Moisture Exchangers - HMEs [A7507]: Any combination of the following Provox Life HMEs (Home, Go, Energy, Night, Protect) or Provox HMEs (XtraMoist, XtraFlow, Luna) to support situational use.	60/mo	
RX	☐ Micron HME [A7507]	60/mo	

RX	PROVOX HME/ADHESIVE ACCESSORIES	QTY	OTHER
	☐ Cleaning Towel [A4245]	1 bx/mo	
	☐ Adhesive Remover Wipes [A4456]	50/mo	
	☐ Skin Barrier OR Skin Tac Wipes [A5120]	150/mo	
	☐ Foam Stoma Cover [A4481]	60/mo	
	☐ Double-Sided Foam Disc [A5126]	20/mo	
	☐ Silicone Glue [A4364]	4/mo	
	☐ Shower Aid [A7523]	1/mo	
	☐ TubeBrush [A4626]	2/mo	
RX	☐ Kapi-Gel [L8499]: **ID mm** ☐ 8 ☐ 12 / **TH mm** ☐ 3 ☐ 5	10/mo	

HANDS-FREE

RX	PROVOX FLEXIVOICE FREEHANDS	QTY	OTHER
RX	☐ Membrane [A7501]: ☐ Light ☐ Med ☐ Strg ☐ XStrg	1/mo	
RX	☐ FreeHands HME [A7507]: ☐ Moist ☐ Flow ☐ Provox Life	60/mo	

RX	PROVOX FREEHANDS ACCESSORIES	QTY	OTHER
RX	☐ HME Cap (Provox Only) [A7503]	1/6mos	
	☐ FreeHands Support Starter Set [E1399]	1/mo	
	☐ FreeHands Support/Adhesive [E1399]	1/mo	

HCP INFO

If you are prescribing more than the standard usage for any product(s), the REQUIRED MEDICAL RECORDS submitted must support the medical necessity for the product(s).

SLP NAME	SLP TELEPHONE	SLP FAX	SLP EMAIL

NOTES PLEASE SEND COPIES OF MEDICAL RECORDS WITH ANY RX

TREATING PRESCRIBER REQUIRED INFORMATION

TREATING PRESCRIBER NAME*	PRESCRIBER NPI
PRESCRIBER TELEPHONE*	ORDER DATE*
PRESCRIBER SIGNATURE* NO STAMPS ALLOWED	SIGNATURE DATE*

The above information is true, accurate, and complete to the best of my knowledge. I confirm that the patient is/was treated by me, and is able to use the supplies prescribed. I verify that the patient's medical condition requires the supplies prescribed, and that the usage quantities are medically necessary. I will maintain a copy of this order in the patient's file.

This is a prescription form only and will NOT automatically generate an order for shipment. RX VALID 12 MONTHS FROM ORDER DATE

*Required

Print Form and Sign