Coloplast® Care Enrollment & Intermittent Catheter Prescription Form

Coloplast

PLEASE ATTACH INSURANCE INFORMATION Email**: care-us@coloplast.com • Fax: 1-855-676-2594

INSTRUCTIONS

- Fill out sections 1 - 9
- Complete all areas in ORANGE
- Attach insurance information
- Provider: sign and date

Click here to email this form

1. PATIENT INFORMATION

☐ Male ☐ Female | ☐ English ☐ Spanish ☐ Other _____ | ☐ Rehab DOB: ____/____/____

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ Phone: _____

By providing an email address the patient consents to the receipt of personalized support through Coloplast® Care Online.

Primary insurance: _____ Secondary insurance: _____

2. DIAGNOSIS

Primary

☐ R33.9 Retention of urine, unspecified ☐ R32 Urge incontinence, unspecified

☐ Permanent ☐ Chronic

☐ Other: _____

Secondary

☐ _____

3. DISPENSING INFORMATION

- Duration of need: ☐ 99 (lifetime) ☐ 12 months
- Number of refills: ☐ 99 (lifetime) ☐ 12 months
- Does patient have a latex allergy? ☐ Yes ☐ No

4. FREQUENCY

☐ 2 per day/60 month/180 per 3 months

☐ 3 per day/90 month/270 per 3 months

☐ 4 per day/120 month/360 per 3 months

☐ 5 per day/150 month/450 per 3 months

☐ 6 per day/180 month/540 per 3 months

☐ 7 per day/210 month/630 per 3 months

☐ ____ per day/____ month/____ per 3 months

5. START DATE _____/_____/_____

6. FRENCH SIZE

☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 16 ☐ 18 ☐ Other: _____

7. PRODUCT

Choose the Coloplast item below or write in the product number if known. If non-Coloplast product is selected, please write in a description.

Product Number _____ Description _____

☐ Dispense as Written

STRAIGHT TIP (A4351*)

SpeediCath® Soft (hydrophilic)
- ☐ 13" Male

SpeediCath® Standard (hydrophilic)
- ☐ 6" Female
- ☐ 6" Pediatric
- ☐ 10" Boy
- ☐ 14" Male

SpeediCath® Compact (hydrophilic)
- ☐ 2.75" Female
- ☐ 3.5" Female Plus

Self-Cath®
- ☐ 6" Female (uncoated)
- ☐ 10" Pediatric (uncoated)
- ☐ 16" Male (uncoated)
- ☐ 16" Soft Male (uncoated)

COUDÉ TIP (A4352*)

SpeediCath® Flex Coudé Pro (hydrophilic)
- ☐ 13" Male Coudé Tip, standard packaging
- ☐ 13" Male Coudé Tip, pocket packaging

SpeediCath® Standard (hydrophilic)
- ☐ 14" Male Coudé Tip

Self-Cath®
- ☐ 16" Male Olive Coudé Tip (uncoated)
- ☐ 16" Male Tapered Coudé Tip (uncoated)

CLOSED SYSTEM/SET (A4353*)

SpeediCath® Compact Set (hydrophilic)
- ☐ 3.5" Female
- ☐ 13.2" Male (12/18 FR)

SpeediCath® Compact (hydrophilic)
- ☐ 13.2" Male (12/18 FR)

SpeediCath® Standard with accessories (hydrophilic)
- ☐ 14" male
- ☐ 6" female

Self-Cath® Closed System (Single Unit)
- ☐ 6" Female
- ☐ 16" Male
- ☐ 16" Soft Male
- ☐ 16" Male Olive Coudé Tip
- ☐ 16" Male Tapered Coudé Tip

LUBRICANT

☐ Packet, each (A4332*) *Typically one packet per cathing episode*

Frequency per day _____ Quantity per month _____

☐ Tube, 4 oz (A4402*)

Frequency per day _____ Quantity per month _____

8. SUPPLIER _____ ☐ No preference (determine best match through Coloplast® Care)

9. PROVIDER INFORMATION

Facility Name: _____ Facility Phone: _____

Facility Address: _____

Facility City: _____ Facility State: _____ Facility Zip Code: _____

Prescribing Clinician Name: _____ NPI#: _____

Provider signature _____ Date _____

My signature acknowledges that I have read the Coloplast® Care Program Description and Terms of Enrollment found on the back of this form to the patient and the patient consented. Stamped signatures are not acceptable.

Order contact name: _____ Email/Mobile _____

PLEASE ATTACH INSURANCE INFORMATION

Email: care-us@coloplast.com • Fax: 1-855-676-2594 • Questions? Call 1-866-226-6362**

Prior to use, refer to product labeling for complete product instructions for use, contraindications, warnings and precautions.

* Reimbursement Disclaimer: Coloplast Corp. provides this information for your general reference and related to the reimbursement of Coloplast products only. Reimbursement, coverage and payment policies can vary from one insurer and region to another, and may change over time. Coloplast does not guarantee coverage or payment of products.

Coloplast® Care Enrollment & Male External Catheter, Leg & Drainage Bags and Foley Prescription Form

Coloplast

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INSTRUCTIONS

- Fill out sections 1 - 8
- Complete all areas in ORANGE
- Attach insurance information
- Provider: sign and date

Click here to email this form

1. PATIENT INFORMATION

☐ Male ☐ Female | ☐ English ☐ Spanish ☐ Other _____ | ☐ Rehab DOB: ____/____/____

First Name:_____ Last Name:_____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ Phone: _____

By providing an email address the patient consents to the receipt of personalized support through Coloplast® Care Online.

Primary insurance: _____ Secondary insurance: _____

2. DIAGNOSIS

Primary

☐ R33.9 Retention of urine, unspecified ☐ R32 Urge incontinence, unspecified ☐ Permanent ☐ Chronic ☐ Other: _____

Secondary ☐ _____

3. DISPENSING INFORMATION

• Duration of need:	☐ 99 (lifetime)	☐ 12 months
• Number of refills:	☐ 99 (lifetime)	☐ 12 months
• Does patient have a latex allergy?	☐ Yes	☐ No

4. FREQUENCY

Male External Catheters
☐ 35 per month/105 per 3 months
☐ Other ___ per day___ per 3 months

Leg Bags
☐ 2 per month/6 per 3 months
☐ Other ___ per day___ per 3 months

Drainage Bags:
☐ 2 per month/6 per 3 months
☐ Other ___ per day___ per 3 months

Foley
☐ 1 per month/3 per 3 months
☐ Other ___ per day___ per 3 months

5. START DATE _____/_____/_____

6. PRODUCT

Choose the Coloplast item below or write in the product number if known. If non-Coloplast product or Foley catheter is selected, please write in brand and description.

☐ Dispense as Written

Product Number_____ Description_____

MALE EXTERNAL CATHETER (A4349*)

Conveen® Optima

☐ Sport Length ☐ Standard Length

☐ 21mm	☐ 25mm
☐ 25mm	☐ 28mm
☐ 30 mm	☐ 30 mm
☐ 35mm	☐ 35mm
	☐ 40mm

LEG BAGS (A4358*)

Conveen® Security+ Leg Bag
☐ 500mL
☐ 1000mL

Conveen® Security+ Contoured Leg Bag
☐ 600mL
☐ 800mL

Conveen® Active Leg Bag
☐ 250mL

DRAINAGE BAGS (A4357*)

Conveen® Standard Drainage Bag
☐ 1500mL

Moveen® Drainage Bag
☐ 2000mL

FOLEY CATHETERS

Brand_____
French Size_____
☐ Pediatric
☐ Non-Latex
☐ Latex (A4338*)

Tip
☐ Straight (A4344*)
☐ Coudé (A4340*)
☐ Open Tip (A4344*)

☐ Foley Insertion Kit (2 per month/ 6 per 3 months)

Balloon Size
☐ 1.5cc
☐ 3cc
☐ 5cc
☐ 10cc
☐ 15cc
☐ 30cc
☐ _____cc

7. SUPPLIER _____ ☐ No preference (determine best match through Coloplast® Care)

8. PROVIDER INFORMATION

Facility Name: _____ Facility Phone: _____

Facility Address: _____

Facility City: _____ Facility State: _____ Facility Zip Code: _____

Prescribing Clinician Name: _____ NPI#:_____

Provider signature _____ Date _____

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Order contact name:_____ Email/Mobile _____

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Coloplast® Care is a free patient support program designed to support patients with intimate healthcare needs. The program includes individualized engagement support which may include a welcome kit, and on-going phone, online and/or email support. Topics discussed include information for living well in the community for as long as enrolled patients desire to receive that educational information from Coloplast.

Coloplast® Care includes active engagement with a dedicated Coloplast® Care Advisor, including direct phone support with information and guidance about proper use of Coloplast products or these categories of products (Ostomy pouches and supporting products, Continence catheters, and Bowel Management). Patients do not need to use Coloplast products to receive support. Education also includes support in locating a product supplier, general reimbursement information, product types, proper use and troubleshooting, as well as on-going self-assessments. Personalized emails contain Coloplast® Care website links to articles, advice, inspirational stories, and answers to lifestyle questions that may be of interest.

By enrolling in Coloplast® Care, independently or through my healthcare provider, I agree that Coloplast may collect, use, transfer, and process personal and health related information about me to process sample requests, conduct research and data analytics, perform other administrative tasks or to comply with applicable law, and to contact me by phone (including my cell phone if that is the number I provided), text message (sms), e-mail, hard copy letter, or other means of communication but only for the purposes referred to above. I also give Coloplast my permission to interact with my healthcare provider or product supplier in connection with the support I receive through Coloplast® Care.

I understand that I can unsubscribe at any time if I do not want to receive communication from Coloplast related to my participation in the Coloplast® Care program any longer. I understand that to unsubscribe, I may call Coloplast at 1-888-726-7872 or I may unsubscribe at any time by clicking the unsubscribe link at the bottom of any email I receive through the Coloplast® Care program.

****We recommend encrypting emails and forms if sending over email.**

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