Coloplast Care Enrollment & Intermittent Catheter Prescription Form

Coloplast

PLEASE ATTACH INSURANCE INFORMATION AND SIGNED PROGRESS NOTES/MEDICAL RECORDS.
We will forward to a supplier and if not included they will contact you directly.

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 (required)
☐ R32 Urinary Incontinence
☐ R33.9 Urinary Retention
} ☐ Permanent (3 mo. Or more)
☐ Other: _____

Secondary (A4352)
☐ N40.0 Benign Prostatic Hyperplasia (BPH)
☐ N35.9 Urethral Stricture
☐ N31.9 Neurogenic Bladder ☐ Other:_____

3. DISPENSING INFORMATION

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

4. FREQUENCY

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

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*)

Luja™ female (hydrophilic)
☐ 3.5" Female (10 FR-16 FR)

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

SpeediCath® Soft (hydrophilic)
☐ 13" Male

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

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

COUDÉ TIP (A4352*)

Luja™ Coudé (hydrophilic)
☐ 13" Male Coudé Tip, standard packaging
☐ 13" Male Coudé Tip, pocket packaging

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

CLOSED SYSTEM/SET (A4353*)

If the patient has had more than one UTI in the past 12 months, or meets criteria such as living in a nursing facility, is immunosupporessed, has documented vesico-ureteral reflux or is a female with SCI and pregnant with neurogenic bladder, please include all relevant signed progress notes/medical records.

SpeediCath® Flex Set (hydrophilic)
☐ 13" Male

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 Olive Coudé Tip
☐ 16" Male ☐ 16" Male Tapered Coudé Tip
☐ 16" Soft Male

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 (Coloplast's affiliated DME supply service)

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
AND SIGNED PROGRESS NOTES/MEDICAL RECORDS.

We will forward to a supplier and if not included they will contact you directly.

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. Suggested documentation requirements are based on Medicare requirements.

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

Coloplast

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

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 ☐ Other: _____

Secondary ☐ _____

3. DISPENSING INFORMATION

- Duration of need: ☐ 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 (Coloplast's affiliated DME supply service)

8. 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 below to the patient and the patient consented. Stamped signatures are not acceptable.

Order contact name:_____ Email/Mobile _____

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

Coloplast Care is a free product and lifestyle educational program designed to support patients with intimate healthcare needs. The program includes individualized product and lifestyle support which may include a welcome kit, and on-going phone, online and/or email support.

Coloplast Care includes 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 of products, as well as on-going self-assessments. Coloplast will honor any supplier designation by clinician or patient, but if none is specified, Care will refer the patient to Coloplast's DME supplier affiliate. Personalized emails contain Coloplast Care website links to articles, advice, inspirational stories, and answers to lifestyle questions that may be of interest.

When you enroll in Coloplast Care, Coloplast will use your information to provide you with education and support, product and lifestyle information, and helpful tips about living with your condition. If you request samples from us, we'll use your information to send, track and deliver your items. We may also call you to check you've received your order and answer any questions you may have about your order. We may let you know about Coloplast's products and services, share inspirational stories from other customers, tell you about upcoming events, and to share your information with Coloplast's affiliated companies, who may reach out regarding related products and services. We may contact you by phone (including your cell phone if that is the number you provide), text message, e-mail, and mail.

We also use the information you share with us to help us understand our customers, their medical conditions, and their needs when treating them. We also use your information to conduct research and data analytics. This helps us to improve our products and services and to develop new ones. We will only process this data on an aggregated level. If you provide photos, we may use these for the above purposes.

We may also share your information with legitimate third parties. For example, we share information with the healthcare provider who referred you to us, or to medical equipment companies from whom you can order supplies. Under very rare circumstances, we might be legally obligated to share your data with public authorities. We do not sell data to third parties.

By enrolling in Coloplast Care, independently or through your healthcare provider, you agree that Coloplast may collect, use, transfer, and process your information for the purposes listed above. You also give Coloplast permission to interact with your healthcare provider or product supplier. You may withdraw your consent at any time, or unsubscribe from communications from Coloplast related to your participation in the Coloplast Care program.

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

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