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 _____ 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

☐ 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.

Dispense as Written

Product Number _____ Description _____

STRAIGHT TIP (A4351*)

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

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

	Frequency per day	Quantity per month
☐ Packet, each (A4332*) *Typically one packet per cathing episode*		
☐ Tube, 4 oz (A4402*)		

8. SUPPLIER Binson's Medical Equipment & Supplies ☐ 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

* 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.

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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 _____ 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 ☐ 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	Leg Bags	Drainage Bags:	Foley
☐ 35 per month/105 per 3 months	☐ 2 per month/6 per 3 months	☐ 2 per month/6 per 3 months	☐ 1 per month/3 per 3 months
☐ Other ___ per day___ per 3 months	☐ Other ___ per day___ per 3 months	☐ Other ___ per day___ 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

Tip	Balloon Size
☐ Straight (A4344*)	☐ 1.5cc
☐ Coudé (A4340*)	☐ 3cc
☐ Open Tip (A4344*)	☐ 5cc
	☐ 10cc
☐ Foley Insertion Kit (2 per month/ 6 per 3 months)	☐ 15cc
	☐ 30cc
	☐ _____cc

7. SUPPLIER Binsons Medical Equipment and Supplies

☐ 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 _____

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 _____

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Coloplast® Care Program Description and Terms of Enrollment: Coloplast® Care is a patient support program designed to provide support for patients who use intermittent catheters in two distinct phases. Phase I relates to individualized engagement support. In Phase II intermittent catheter users are provided with on-going online and email support for living well in the community - for as long as enrolled individuals desire to receive that educational information from Coloplast.

Coloplast® Care Phase I incorporates active engagement with a dedicated Coloplast® Care Advisor, including direct phone support with information and guidance about intermittent catheters, proper use of Coloplast products, support locating a product supplier, as well as information regarding product reimbursement.

The transition into Phase II occurs when each individual has become more independent and confident with his or her product and daily routines. Phase II is designed to provide on-going relevant information and support via email contact for each stage in the intermittent catheter journey. 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 your healthcare provider, I agree that Coloplast may 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 option of any email I receive through the Coloplast® Care program.