

Ciampa Apothecary

425 Cambridge St
Cambridge, MA 02141
Phone: 617-547-0322
Fax: 617-497-4021

Date:

Patient Name:

Date of Birth:

Doctor Name:

Doctor Fax #:

**Please remember to fax us a prescription
along with this form!**

If you have any questions, please do not hesitate to call us. Thank you!

Medical Necessity Review Form for Absorbent Products

Please fax to: Ciampa Apothecary 617-497-4021

Member's Name		Member's MassHealth ID no:		DOB
Member's Address				
Primary Diagnosis causing the incontinence:			Secondary Diagnosis causing the incontinence (if applicable):	
Signs and symptoms of Incontinence (check all that apply): <input type="radio"/> Stress Incontinence <input type="radio"/> Urge Incontinence <input type="radio"/> Mixed Incontinence <input type="radio"/> Overflow Incontinence <input type="radio"/> Total Incontinence <input type="radio"/> Other (specify): _____			Risk Factors (check all that apply): <input type="radio"/> Impaired mobility <input type="radio"/> Urine culture and sensitivity <input type="radio"/> Post-void residual determination <input type="radio"/> Other (specify): _____	
Possible reversible factors: <input type="radio"/> Symptomatic urinary tract infection <input type="radio"/> Environmental conditions <input type="radio"/> Medical Conditions <input type="radio"/> Medications <input type="radio"/> None <input type="radio"/> Other (specify): _____			Type of treatment initiated: <input type="radio"/> None <input type="radio"/> Behavioral <input type="radio"/> Pharmacological: <input type="radio"/> Surgical <input type="radio"/> Other (specify): _____ Expected to improve? Yes No	
Pt Height		Pt Weight		Location where patient will use item (please circle) Home Work Other _____
Duration of Need:			Number of Refills:	

Product (please check all that apply)	Size/Type (please circle)	Quantity Per Month
<input type="radio"/> Diapers (adult sized, tab style)	Sm Med Lg XL	_____
<input type="radio"/> Pull ups (adult sized, must complete box below)	Sm Med Lg XL	_____
<input type="radio"/> Liner/Shield	Disposable Reusable	_____
<input type="radio"/> Underpad	Disposable Reusable	_____

Please answer the following questions only if you are requesting pull up style diapers

- Has the member participated in a toileting-assistance program or is such a program impractical for the patient?
Yes _____ No _____
- Does the member have the cognitive and physical ability to pull up and take off the diaper on his/her own?
Yes _____ No _____
- Is the patient able to ambulate and not bedridden?
Yes _____ No _____

Prescriber Name:	DME Provider: Ciampa Apothecary
Address:	Address: 425 Cambridge St. Cambridge, MA 02141
Phone number:	Phone #: 617-547-0322 Fax #: 617-497-4021
NPI:	MassHealth Provider #: 110020689A

Attestation: I certify that the clinical information provided on this form is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may be subject to civil or criminal liability.

Prescriber attestation (signature)

Date