COLORADO
Department of Health Care Policy & Financing

Kepro

Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219	**ColoradoPAR Program** Medical Review Department	Phone: 1-720-689-6340 Fax: 1-800-922-3508

QUESTIONNAIRE #12
WOUND CLOSURE THERAPY (VACUUM)

Member Name		Health First Colorado ID #	

Length of Need		Height		Weight	

The information requested below is required to determine medical necessity. Complete this form and attach to the completed Prior Authorization Request (PAR).

1. Describe wound and include: location, stage, size, depth, any tunneling, etc.	
2. Describe previous wound treatment, if any.	
3. Does the member have osteomyelitis?	□ Yes □ No
4. Does the member use a pressure-reducing surface? a. If yes, describe.	□ Yes □ No
5. If the member is over 18 and has an albumin level less than 3 mg/dl, list the albumin level and describe the type of nutritional support that the member is receiving or requires. **Note**: Normal range is greater than 3mg/dl.	
6. Is the member's wound free of necrotic infection? a. If the wound has recently been debrided, identify the type and date of debridement.	□ Yes □ No □ Surgical □ Chemical □ Physical □ Autolytic **Date** **Date** **Date** **Date**
7. Will the member's overall health status, including nutritional status, affect wound healing? a. Describe all medical conditions that might affect wound healing. Address incontinence and what is being done to decrease the contamination of the wound.	□ Yes □ No
8. Supply any additional information that will assist us in determining **medical necessity** for this request:	

Note: If measurable improvement is not seen after four weeks, the physician must reassess the member. If measurable improvement, the physician may assess the member for continued use of therapy every 62 days.

Print Prescriber Name _____

Prescriber Signature _____

Date _____

Revised July 2021