# QUESTIONNAIRE #12
## WOUND CLOSURE THERAPY (VACUUM)

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Health First Colorado ID #</th>
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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

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