Prior Authorization Request
5802 Benjamin Center Dr., Suite 105
Tampa, FL 33634

ColoradoPAR Program
Medical Review Department

Phone: 1-888-801-9355
Fax: 1-866-940-4288

QUESTIONNAIRE #12
Wound Closure Therapy (Vacuum)

Client Name:		Colorado Medicaid ID #:	

Length of Need:		Height:	
		Weight:	

The information requested below is required to determine medical necessity. After you have completed this form, attach it to the completed Prior Authorization Request (PAR).

1) Wound description, including: location, stage, size, depth, any tunneling, etc.	
2) Previous wound treatment:	
3) Does client have osteomyelitis?	☐Yes ☐No
4) Does the client use a pressure- reducing surface? a.) If yes, describe:	☐Yes ☐No
5) If the client is over 18 and has an albumin level less than 3 mg/dl, please list the albumin level and describe the type of nutritional support that the client is receiving or requires. (Normal range: greater than 3mg/dl)	
6) Is the client'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 client'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) Please supply any additional information that will assist us in determining **medical necessity** for your request:	
If measurable improvement is not seen after four weeks, the physician must reassess the client. If there is measurable improvement, the physician may assess the client for continued use of therapy every 62 days.	

Print Prescriber Name ______________________________

Prescriber Signature ______________________________ Date ______________

Revision Date: 09/15