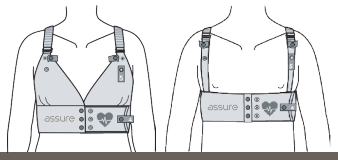
assure®
Wearable Cardioverter Defibrillator



# ASSURE WCD Medical Order Form (Complete All Fields)

## PATIENT INFORMATION AND CONDITION

**Patient First and Last Name (Please Print)** _____

Address _____

Date of Birth (MM/DD/YYYY) _____

Anticipated Discharge Date (MM/DD/YYYY) _____ WCD Start Date (MM/DD/YYYY) _____

☐ New Order ☐ Renewal

Length of Need: Six Months (Default)
Specify Alternative Duration (Months): _____

**Select Indication Below for ASSURE WCD** (HCPCS: K0606)
Refer to the following page for required documentation.

- ☐ Documented VF or Sustained VT
- ☐ Familial or Inherited Condition with SCA Risk
- ☐ Prior MI With EF ≤ 35%
- ☐ DCM (including NICM) With an EF ≤ 35%
- ☐ ICD Explantation
- ☐ Other Condition With High Risk of VT/VF (Specify): _____

## ASSURE WCD SETTINGS (ALL SHOCKS 170J)

| Select One | VT Zone | VF Zone |
|---|---|---|
| ☐ **Patient History of Atrial Fibrillation, Atrial Flutter, or other SVT** | 180 bpm | 220 bpm |
| ☐ **Default/Nominal Settings** (Will Be Used if Section Is Left Blank) | 170 bpm | 200 bpm |
| ☐ **Custom Settings** (Enter in Increments of 10 bpm) | _____bpm (130–210) ☐ Monitor Only (VT Zone Only) | _____bpm (180–220) VT Zone + 10 bpm (Minimum) |

## PRESCRIBER INFORMATION

Prescriber's Designated Contact Person _____ Contact Person's Phone Number _____

**Prescriber First and Last Name (Please Print)** _____

**Prescriber NPI#** _____

**Prescriber Signature** (Do Not Stamp) _____ **Signature Date** (MM/DD/YYYY) _____

KMTS-00005-03_K

**FAX COMPLETED FORM TO (877) 371-2202**

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## DOCUMENTATION REQUIREMENTS

### Required Documentation for Every Order:

- Medical Order (completed, signed, and dated; see previous page)
- Patient face sheet
- H&P, progress note, clinical tests/reports, consultation or discharge summary
- Continuing arrhythmia treatment plan, including ICD*

*Note: Certain states and insurers may have additional requirements. Your Kestra representative can provide more information.

### Supplemental Documentation Per Indication (See Previous Page) May Include:

| | |
|---|---|
| **Cardiac arrest due to VF or sustained VT** | • Date and proof of arrhythmic event<br>• EMS report<br>• EP study report with induced VF or sustained VT |
| **Familial or inherited condition with sudden cardiac arrest (SCA) risk** | • Cardiac condition diagnosis and description |
| **Prior myocardial infarction (MI) with EF ≤ 35%** | • Date of MI<br>• Cath/echo report, consultation, or discharge summary<br>• EF measurement<br>• Date of EF measurement |
| **Dilated cardiomyopathy (DCM) (including NICM) with EF ≤ 35%** | • Cath/echo report<br>• Cardiac diagnosis<br>• EF measurement<br>• Date of EF measurement |
| **ICD explantation** | • Date of ICD explant<br>• Reason for ICD explant |
| **Other condition with high risk of VT/VF (specify)** | • Cath/echo report<br>• Diagnosis and explanation of high-risk condition |

THANK YOU FOR EVERYTHING YOU DO TO CARE FOR YOUR PATIENTS. WE'RE HERE TO HELP.

kestra
MEDICAL TECHNOLOGIES

Phone: (833) 692-7787 (Toll free)
www.kestramedical.com
Kestra Medical Technology Services, Inc.

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