PHILIPS

Philips Remote INR
Physician order for PT/INR patient self-testing

Complete all sections. To avoid delay in processing, completion of fields with (*) is required.

- ○ Sign and date the form.
- ○ Fax the completed form to Philips Remote INR Patient Services at 1-800-779-8560.
- ○ Send signed and dated clinical documentation of the intent for ordering test materials and/or equipment for home INR monitoring of patient.
- ○ If available, provide POA documentation.

1

Patient first name*	MI	Last name*	Legal gender	DOB (mm/dd/yyyy)*
			_ M _ F	
Home address*		City*	State*	Zip/postal code*
Home phone #* 1-	Cell phone # 1-		Patient email (if available)	
MRN # (Medical record number, if applicable for EHR connectivity)				

2 Patient diagnosis code*

Based on diagnosis of the patient's condition, enter all the applicable ICD-10 diagnosis codes. Below are commonly used ICD-10 diagnosis codes for patients who are monitoring PT/INR at home. This is not a complete list of possible codes. You may also enter separate code(s) in **Other**. For a full list of ICD-10 codes recognized by CMS, please visit https://www.cms.gov. All diagnosis codes must be provided in ICD-10 format.

- ○ **Z79.01** - Long term (current) use of anticoagulants
- ○ **I48.11** - Longstanding persistent atrial fibrillation
- ○ **I48.21** - Permanent atrial fibrillation
- ○ **I48.0** - Paroxysmal atrial fibrillation
- ○ **Z95.2** - Presence of prosthetic heart valve
- ○ **I26.99** - Other pulmonary embolism without acute cor pulmonale
- ○ **D68.59** - Other primary thrombophilia
- ○ **Other** -

3 Therapeutic range

Low*: _____

High*: _____

4 Notification range

- ◉ **Do not call for any INR results.***
  *This is default option if no option is selected.
- ◉ **Call if INR result is <1.5 and >5.0**
- ◉ **Call for customized notification range if result is below _____ or above _____**

Notification below cannot be greater than therapeutic low. Notification above cannot be greater than therapeutic high.

5 Prescribed frequency

Tests per month (select one)*

Frequencies outside of this range are not offered by Philips:

- ○ **Weekly**
- ○ **2-4 Times per month** (flexibility to test weekly or bi-weekly)

6 Patient results contact (All results will be faxed and notification calls will be made per your choice in section 4)

Phone (Out of range)* 1-	FAX (All results)* 1-	Medical Records Phone 1-	Medical Records Fax 1-	
Practice/Clinic name				
Clinic street address*	Suite #	Clinic city*	Clinic State*	Clinic zip*

7 Patient training face-to-face training is required*

- ○ **Already Trained** – Physician certifies patient was face-to-face trained on the Philips Remote INR PT/INR monitoring system
- ○ **Philips Train** – Philips will attempt to train patient
- ○ **Clinic Train** – Training contract with Philips must be in place

Notes:
- If patient has previously been on service with Philips Remote INR, and it has been documented that a training has already taken place, we reserve the right to bypass face to face training.
- Philips Remote INR Patient Services will attempt to train your patient unless one of the other options above is selected (training is not guaranteed).

8 Physician authorization (Signature and date must be hand-written or e-signed)

This form serves as a Physician's Order for the Philips Remote INR PT/INR monitoring system for Patient Self-Testing and related supplies. I certify that this patient has been on oral warfarin therapy for more than 3 months and is a suitable candidate for self-testing. At this time, the patient or his/her caregiver has no condition that makes self-testing unsafe (e.g., cognitive and/or physical disorders). I agree to notify Philips Remote INR if self-testing is no longer prescribed for this patient. I acknowledge that this product is intended for patients 22 years of age and older, and use outside of the intended population is off-label use. Evaluation of risk of use on patients under 22 is determined by the device manufacturer. Use outside of the intended population is not endorsed by Philips.

Sign & date — Prescribing physician signature*	Date (mm/dd/yyyy)*	Physician NPI*
Prescribing physician printed*		

9 Insurance information To expedite patient enrollment please include a copy of front and back of patient's insurance card

	Insurance company	Policy ID#	Customer service phone #
Primary health insurance information			1-
Secondary health insurance information			1-

Please fax completed form to the central office Phone: 1-800-780-0675 Fax: 1-800-779-8560 Alt Fax: 1-877-740-1831

Philips Remote INR uses CoaguChek supplies and monitors for INR self testing. CoaguChek is a trademark of Roche Diagnostics.