Washington State Department of Labor & Industries

Negative Pressure Wound Therapy

Preauthorization & Continued Authorization Request Form

Office of the Medical Director
Occupational Nurse Consultants
PO Box 44315
Olympia WA 98504-4315

Fax completed forms to: 360-902-9170

Preauthorization ☐
30-Day Review ☐ 1st ☐ 2nd ☐ 3rd

- For preauthorization, the nursing staff caring for this worker must complete the entire form.
- For each 30-day review, please complete sections I, III, and V.
- All information must be current within 30 days of service date. You must keep appropriate documentation to substantiate this information in your files.
- All current, dated photos of the wound and a copy of the physician's prescription must accompany this form.

I. Worker Information

Worker's Name	L&I Claim Number	
Name of Nursing Facility/Nursing Service/Home Health Agency		
L&I Provider ID	Telephone Number	Fax Number
Prescribing Provider Name		
Prescribing Provider's L&I Provider ID	Telephone Number	Fax Number
Service Dates	Estimated Length of Treatment	

II. Previous Treatment

The following complete Wound Therapy Program must be tried and failed prior to negative pressure wound therapy request.

- Evaluate, care, and wound measurements. ☐ Yes ☐ No
- Application of dressing to maintain a moist wound environment. ☐ Yes ☐ No
- Debridement of necrotic tissue, if present. ☐ Yes ☐ No
- Evaluation of provision for adequate nutritional status. ☐ Yes ☐ No
- Standard forms of treatment specific to the type of wounds. ☐ Yes ☐ No

List all treatment/dressings tried and failed. Include timeframe for each treatment/dressing.

III. Wound Evaluation

	A.	B.	C.
Location			
Size (width and length)			
Depth			
Tunneling			
Drainage (None, Minimum, Moderate, or Heavy)			

Worker's Name	L&I Claim Number

IV. Wound Type				
A. Surgical? ☐ Yes ☐ No If yes, answer the following questions:				
Type of Surgery:				
Date of Surgery:				
Date of Dehisced:				
B. Pressure? ☐ Yes ☐ No If yes, answer the following questions:				
Support Surface in Use? ☐ Yes ☐ No				
If yes, what kind/name?				
Moisture/Incontinence Managed? ☐ Yes ☐ No				
C. Neuropathic (diabetic) Ulcer? ☐ Yes ☐ No If yes, answer the following questions:				
Patient on a comprehensive diabetic management program? ☐ Yes ☐ No				
Reduction of pressure on a foot ulcer was accomplished with offloading? ☐ Yes ☐ No				
D. Venous Stasis Ulcer? ☐ Yes ☐ No If yes, answer the following questions:				
Compression bandages/garments consistently applied? ☐ Yes ☐ No				
Is leg(s) elevated? ☐ Yes ☐ No				
Is client ambulating? ☐ Yes ☐ No				

V. Contraindications (FDA Safety Communication)	
Is wound clean and free of necrotic tissue/eschar? ☐ Yes ☐ No If "No", why?	
Is untreated osteomyelitis present within the vicinity of the wound? ☐ Yes ☐ No	Exposed nerves? ☐ Yes ☐ No
Is cancer present in the wound? ☐ Yes ☐ No	Exposed anastomotic site? ☐ Yes ☐ No
Is there a fistula to an organ or body cavity within the vicinity of the wound? ☐ Yes ☐ No	
Exposed organs? ☐ Yes ☐ No	Exposed vasculature? ☐ Yes ☐ No

VI. Labs			
Date Drawn			
Albumin; Pre	Hematocrit	Hemoglobin	If diabetic, need HgbA1C

- Attach medical/clinical notes from last two visits and two wound care notes, including all medical conditions.
- Last two visits notes may be from hospital nursing/physician notes.
- Include colored wound photos. Photos must include measurement tool demonstrating wound size.

Print Nursing Staff Name

Title

Nursing Staff Signature

Date

RESET