



**Presbyterian Salud/NMRx
Disposable Diapers Pharmacy Exception Form
(GENERIC DIAPERS ONLY)**

Patient Name: _____ Date of Birth: ____/____/____

ID Number: _____ SSN: _____

Number of Diapers Requested: _____ (Max 200/month) Length of Treatment: _____

Please **provide chart notes for all requests** about patient's condition and functional level, and how these factors relate to the patient's need for diapers **DIAGNOSIS** (related to necessity for diapers) _____

Describe any conditions related to a neurological or a neuromuscular disorder: _____

Describe any profound cognitive disability that results in an inability to achieve continence through bladder training: _____

Is incontinence due to any factor outside of the urinary tract? (Description) _____

- Does the patient have a diagnosis of stress incontinence Yes _____ No _____
- Is patient age greater than 3 years. Yes _____ No _____
- How many diapers will member use per day? _____
- Is the patient institutionalized? Yes _____ No _____
Type of Facility: _____SNF _____Hospice _____Nursing Home _____Assisted Living
- Does incontinence cause significant soiling that requires clothes, bed to be immediately changed, or which macerates skin or exacerbates decubitus ulcers? Yes _____ No _____
- Can patient be managed successfully with a bedside commode or other assistive devices? Yes ____ No ____

Print Physician Name: _____ Phone: _____

Physician Specialty: _____ Date: _____

Physician Signature: _____ Fax: _____

****Phone and Fax Number REQUIRED****

All of the above information must be completed in order to process the request.

Fax completed Form to Presbyterian Pharmacy Services to **1-800-724-6953** or **(505) 923-5540**.

If you have any questions, please call (505) 923-5757 or 1-888-923-5757

FOR PRESBYTERIAN USE ONLY

Approved: _____ Denied: _____ PA #: _____

Reviewed by: _____ Date: _____

Medical Director: _____ Date: _____

Comments: _____

CONFIDENTIAL: PROTECTED HEALTH INFORMATION ENCLOSED

Protected Health Information (PHI) is personal and sensitive information related to a person's health care. It is being delivered to you after appropriate authorization from the patient/member or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure of failure to maintain confidentiality could subject you to penalties described in federal and state law.