Washington State Health Care Authority

Durable Medical Equipment (DME) Program Management Unit
PO Box 45535
Olympia, WA 98504-5535
FAX: 1-866-668-1214

Medical Necessity For Authorization Of Catheters

The Health Care Authority (HCA) requires this form for all clients requesting sterile closed catheter. Do not alter this form in any way. The form may be completed only by a provider acting within the scope of your practice. You must complete all spaces. The form must be signed and dated within 60 days of HCA receiving the request. This form is required in addition to a prescription.

DATE OF REQUEST	CLIENT ID
PATIENT NAME	
Diagnosis	
Item requested	

Please check all that apply to your patient:

☐ The patient has/had documented recurrent urinary tract infections (UTI) while on a program of clean cathing, twice within a 12-month period prior to beginning sterile cathing

Please list the following and provide copies of lab reports;

- Date of UTIs:
- Antibiotics used:

A urinary tract infection is indicated by a urine culture with more than 10,000 colony-forming units of a urinary pathogen and a concurrent presence of one or more of the following signs, symptoms, or lab findings. Check those that apply to your patient.

☐ Fever; state temperature in degree _____
☐ Change in urinary urgency, frequency, or incontinence
☐ Appearance of new, or increase in, autonomic dysreflexia (sweating, bradycardia, blood pressure elevation)
☐ Physical signs of prostatitis, epididymitis, orchitis
☐ The patient is immunosuppressed (on a regimen of immunosuppressive drugs, cancer chemotherapy, or has AIDS)
☐ Pyuria (greater than 5 WBCs per high-powered field)
☐ Systemic leukocytosis

How many times per day does the patient catheterize?

☐ 2-4 times ☐ 4-6 times ☐ 6-8 times ☐ 8 times or more

Additional Comment

Physician's Name (print)	Referring Physician Telephone
Telephone	FAX
Physician's Signature	Date