DETAILED WRITTEN ORDER FOR NAVINA™ SYSTEMS

Navina™

1

Patient Name _____ Date of Birth _____

*Patient Address _____

*For **California**, address is required

Phone _____ Email Address _____ *Order Date* _____

2 ICD-10 Diagnosis

❑ K59.2 Neurogenic bowel ❑ Other _____

Related to: ❑ SCI (level of injury) _____ ❑ Multiple Sclerosis ❑ Spina Bifida ❑ Other _____

Patient history (Please check all that apply): ❑ History of chronic fecal incontinence ❑ Chronic constipation

3 Plan of Care

Navina transanal irrigation to be performed: ❑ Daily ❑ Every other day | Length of need: _____ months (99=lifetime)

Check Box	Navina Classic	Product #	Check Box	Navina Smart	Product #
❑	Navina Classic System (starter kit)	6910540	❑	Navina Smart System	6910940
	Consumable Set Regular (15 regular catheters, 1 water container)	6900340		Consumable Set Regular (15 regular catheters, 1 water container)	6900340
	Navina Classic System Refill (to be ordered after every 100 uses following initial starter kit order)	6910640		Navina Tube Set (to be ordered after every 100 uses following initial Navina Smart System order)	6901140
❑	Navina Classic System (starter kit)	6910540	❑	Navina Smart System	6910940
	Consumable Set Small (15 small catheters, 1 water container)	6900440		Consumable Set Small (15 small catheters, 1 water container)	6900440
	Navina Classic System Refill (to be ordered after every 100 uses following initial starter kit order)	6910640		Navina Tube Set (to be ordered after every 100 uses following initial Navina Smart System order)	6901140
❑	Navina Classic System (starter kit)	6910540	❑	Navina Smart System	6910940
	Consumable Set Cone (15 cone catheters, 1 water container)	6901640		Consumable Set Cone (15 cone catheters, 1 water container)	6901640
	Navina Classic System Refill (to be ordered after every 100 uses following initial starter kit order)	6910640		Navina Tube Set (to be ordered after every 100 uses following initial Navina Smart System order)	6901140

❑ I have reviewed the patient's medical records and the items requested above. I verify that the patient's medical condition requires the supplies described and that the usage quantities are medically necessary. I will maintain a copy of this prescription in the patient's file to comply with the carrier's requirements.

❑ I agree that the patient may receive the mandatory Navina Systems transanal irrigation training with a healthcare professional familiar with the Navina Systems via a virtual video meeting and carry out their first Navina transanal irrigation at home without healthcare professional supervision.

❑ I have read and understand the Navina Classic/Smart instructions for use containing indications, contraindications, precautions/special care, warnings, and important safeguards and have reviewed them with the patient and/or caregiver. Also, that training sessions with a healthcare professional specialized in TAI and familiar with Navina Systems are mandatory before using Navina Systems independently. The first irrigation should be performed under supervision of a healthcare professional.

Prescriber's Name _____ Phone _____

Facility _____ Fax _____

Address _____ City, State, Zip _____

NPI# _____ Prescriber's Signature _____ No Stamps Date _____ No Stamps

All changes MUST be initialed and dated by PRESCRIBER

Please COMPLETE and send with CHART NOTES, INSURANCE CARD & DEMOGRAPHICS to Fax# 1-866-666-6250

BL-SUS-3010:E

CUSTOMER SERVICE HELPLINE: 877.456.3742

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