Clarify Medical™ Home Light Therapy

Prescription and Written Order Form

Fax completed form to (844) 562-6896 or email to: 18445626896@efaxsend.com

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ Phone _____ Gender: ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____

Prescription Information

Description	ICD-10 *(check one)*
Psoriasis	☐ L40 . ____
Vitiligo	☐ L80
Other	☐ _____ . __

Skin Type: *(check one)*

☐ I ☐ IV
☐ II ☐ V
☐ III ☐ VI

Treatment Protocol: *(check one)*

☐ Clarify Standard
☐ Clarify Vitiligo

Treatment Duration*: *(check one)*

☐ 6 months ☐ 12 months
☐ Ongoing ☐ Other: _____

*System will be disabled at the end of treatment duration.

Diagnosis and Statement of Medical Necessity

Severity *(check one)*

☐ Severe
☐ Moderate
☐ Mild

List Previous Treatments:

_____
_____
_____

Was it Effective?

☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No

Reasons for Home Use: *(check all that apply)*

☐ Therapy is Considered Long Term
☐ Distance and Travel Time to Office
☐ Co-pay Cost of Frequent In-Office Visits
☐ Other: _____

Has patient ever been treated w/ UV Light Therapy in the past? Either in the office or at home? ☐ Yes ☐ No

If yes, did the patient respond to phototherapy? ☐ Yes ☐ No

Is the patient and/or caregiver reliable, motivated and able to adhere to instructions? ☐ Yes ☐ No

Prescriber Information

First Name _____ Last Name _____ ☐ MD ☐ DO ☐ NP ☐ PA

State Medical License/ NPI # _____ Practice Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

I certify that I am the physician identified on this form. I have reviewed this prescription and written order. Any statement on my letterhead attached has been reviewed and signed by me. I certify that the patient and/or authorized caregiver is capable and willing to be trained by Clarify Medical on proper home use of the prescribed Home Light Therapy System product.

I understand that Clarify and its CarePartners do not furnish medical advice or make medical decisions related to the Home Light Therapy System and that I (and, as applicable, other health care providers) am responsible for medical decisions and treatment options including any decision to prescribe the Home Light Therapy System or suspend or discontinue the prescription in the event of patient non-compliance.

All prescriptions are valid for 6 months from the date the prescription is written. If patient does not begin therapy within 6 months of the prescription being written, this prescription form will be voided, and a new prescription will be required to begin therapy. Duration of treatment begins from the date the patient is onboarded and completes first treatment with the Clarify System.

Signature _____ Date _____

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Clarify Standard Protocol: Psoriasis, Eczema and Other

Treatment Frequency: 3 times per week

Skin Type	Initial Dose (mJ/cm²)	Dose Increase (mJ/cm²)	Dose Reduction (% Previous)	Maximum Dose (mJ/cm²)
I	130	15	25	2000
II	220	25	25	2000
III	260	40	25	3000
IV	330	45	25	3000
V	350	60	25	5000
VI	400	65	25	5000

Days Missed Between Treatments

Days Missed	Action	Dose Reduction (% Previous)
1-3	Continue plan	0
4-7	Maintain last dose	0
8-14	Decrease dose	25
15-21	Decrease dose	50
>22	Restart at initial dose	0

Maintenance

Step	Dose Reduction (% of Peak)	Frequency	Duration (Weeks)	If condition unchanged, go to:	If condition worsens, go to:
Step 1	0	1 time per week	4	Step 2	Treatment
Step 2	25	1 every 2 weeks	4	Step 3	Step 1
Step 3	50	1 every 4 weeks	4	End Maintenance	Step 2

Reference: Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. *J Am Acad Dermatol. 2010:62:114-35*

Clarify Vitiligo Protocol

Treatment Frequency: 3 times per week

Skin Type	Initial Dose (mJ/cm²)	Dose Increase (% Previous)	Dose Reduction (% Previous)	Maximum Dose (mJ/cm²)
I-III	200	10	15	3000
IV-VI	200	15	15	5000

Days Missed Between Treatments

Days Missed	Action	Dose Reduction (% Previous)
1-3	Continue plan	0
4-7	Maintain last dose	0
8-14	Decrease dose	25
15-21	Decrease dose	50
>22	Restart at initial dose	0

Maintenance

Step	Dose Reduction (% of Peak)	Frequency	Duration (Weeks)	If condition unchanged, go to:	If condition worsens, go to:
Step 1	0	2 times per week	4	Step 2	Treatment
Step 2	0	1 time per week	4	Step 3	Step 1
Step 3	0	1 every 2 weeks	8	End Maintenance	Step 2

Reference: Mohammad TF, Al-Jamal M, Hamzavi IH, et al. The Vitiligo Working Group recommendations for narrowband ultraviolet B light phototherapy treatment of vitiligo. *J Am Acad Dermatol; 2017:76(5):879-888*