

Beneficiary Full Name: \_\_\_\_\_

Sponsor's SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Beneficiary State of Residence: \_\_\_\_\_

Dear Provider,

Please complete and sign this letter of attestation below and return as indicated on the additional information request letter or attach it to your online request. *Requests for **Varithena**® (polidocanol injectable foam) must also include a copy of the Doppler or duplex ultrasound report that documents vein incompetence.*

1. Which of the following is the patient experiencing?

- Persistent symptoms interfering with activities of daily living in spite of conservative/non-surgical management
- Significant recurrent attacks of superficial phlebitis hemorrhage from a ruptured varix
- Ulceration from venous stasis where incompetent varices are a contributing factor
- None of the above

Periodic elevation of legs for \_\_\_\_\_ months

Response: \_\_\_\_\_

Compressive stockings for \_\_\_\_\_ months.

Response: \_\_\_\_\_

Other (please specify treatment, duration, and response)  
\_\_\_\_\_  
\_\_\_\_\_

2. Which symptoms are present, if any?

- Aching
- Cramping
- Burning
- Itching
- Swelling during activity or after prolonged standing
- None of the above

4. Is the patient's anatomy amenable to the procedure?

Yes  No

3. Which of the following conservative, non-operative treatments have been attempted?

Please specify for how long and the response.

Mild exercise for \_\_\_\_\_ months.

Response: \_\_\_\_\_

Avoidance of prolonged immobility for \_\_\_\_\_ months.

Response: \_\_\_\_\_

5. List of veins to be treated with Varithena (side, location is mandatory) and reflux measurements for all:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Prior endovenous treatments done, if any, and date performed:  
\_\_\_\_\_  
\_\_\_\_\_

7. If the request for Varithena is within three months of endovenous treatment and sclerotherapy, specify why a 3-month waiting period to determine the success of the endovenous procedure is not needed:  
\_\_\_\_\_  
\_\_\_\_\_

I attest the information provided is true and accurate to the best of my knowledge. I understand Health Net Federal Services, LLC or designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Additional information: \_\_\_\_\_

Physician's printed name and title: \_\_\_\_\_

TIN: \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

This document may contain information covered under the Privacy Act (5 USC §552a) and/or the Health Insurance Portability and Accountability Act (P.L. 104-191) and its various implementing regulations and must be protected in accordance with those provisions. If you have received this correspondence in error, please notify 1-844-866-WEST (9378) at once and destroy the documents and any copies you have made.

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