



Remote Therapeutic Monitoring

1. Does the member's Plan of Care include Remote Therapeutic Monitoring? Please select one.

Yes No

If question 1 is answered "yes":

- 1.1 Name of the Remote Therapeutic Monitoring Device or Application:

2. Does the Remote Therapeutic Monitoring device or application meet the FDA definition of a medical device described in section 201(h) of the Federal Food, Drug and Cosmetic Act? Please select one.

Yes No

3. Has the Remote Therapeutic Monitoring device or application been proven by evidence to be effective? Please select one.

Yes No

4. Has the required Questionnaire 20 been attached or uploaded to the review and signed by the prescriber? Please select one.

Yes No

5. Has the member been monitored for the minimum requirement of 16 days out of 30 for the calendar month? Please select one.

Yes No

6. Is the Remote Therapeutic Monitoring being performed by qualified personnel? Please select one.

Yes No

