eNeura®

Customer Care: 1-855-366-8355
Customercare@eneura.com
Fax: 1-877-874-9584

PHYSICIAN INFORMATION: All requested information must be provided in order to process the prescription.

First Name:_____Last Name:_____MD/DO/CRNP/PA

NPI#:_____Tax ID#:_____

Practice Name: _____

Office Contact Name: _____ Email Address: _____

Address:_____City:_____State: _____ Zip:_____

Ph. #_____ FAX #: _____

sTMS mini™ PRESCRIPTION and PROVIDER AUTHORIZATION

Patient Name: _____ Patient DOB: _____ M ☐ F ☐

First, Middle Initial., Last, Other Initials

Patient Address: _____

Patient Email address:_____Phone #:_____

(email address is needed to send enrollment forms)

Diagnosis: ICD-10 Code: ☐ G43.009 ☐ G43.909 ☐ G43.901 ☐ G43.101 ☐ G43.109 ☐ G43.111 ☐ G43.119 ☐G43.709

☐Other_____ (Diagnosis code *must* be included to attain insurance benefit/coverage)

The eNeura Access Team will work with your patient in obtaining funding and/or insurance options.

☐ **Dispense 90 days of sTMS mini™ (1 unit)**

Refills: ☐ 1 ☐ 2 ☐ 3 ☐ 4 Maximum Number of Refills: 4

Initial Dispense includes **sTMS mini™** device and SIM Rx card. Fills and refills are subject to standard billing and payment policies unless otherwise determined.

☐ **Titrate to relief. Preventive Therapy:** 4 pulses BID as tolerated **Acute Therapy:** 4 pulses, repeat as needed

☐ **Other**_____

By signing below, I certify that (a) the above-prescribed therapy is medically necessary, and (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the above-prescribed therapy, to eNeura and its agents or contractors for the purpose of seeking information related to coverage for the therapy and/or assisting in initiating or continuing therapy. New York State prescribers must submit a prescription on an original New York State prescription blank along with this completed form.

Prescriber's Signature (No Stamps):_____**Date:** _____