

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:** _____