eNeura

Fax: 1-877-264-1818
Phone: 1-833-499-9300, Option 1
Customercare@eneura.com

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

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

NPI#:_____

Practice Name: _____

Office Contact Name: _____Email Address:_____

Address:_____City:_____State: _____ Zip:_____

Ph. #_____ FAX #: _____

SAVI™ and sTMS mini™ PRESCRIPTION and PROVIDER AUTHORIZATION

Patient Name: _____ Date of Birth:_____Gender: _____

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 ☐G43.711 ☐G43.719 ☐G43.809 ☐G43.811
☐ Other:_____ **Diagnosis Code is Required**

☐ **Dispense SAVI™ Device and 90-days treatment (1 unit)**

SAVI (STMS) Refills ☐ 1 ☐ 2 ☐ 3 ☐ 4 **Maximum Number of Refills: 4.** *(Each refill = 90-day dispense)*

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

☐ **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.

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