We cannot process the Rx without a copy of the Outpatient Facesheet.

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Healthcare Provider 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 Dual™ Migraine Therapy 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

SAVI Dual™ Migraine Therapy Device Dispense NDC # 161400020-13

Initial treatment 3 months minimum

Refills: **Maximum Number of Refills: 12.** *(Each refill = 30-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:** _____