

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 #: _____

sTMS 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

☐ Dispense sTMS Migraine Therapy Device

☐ # _____ Refills (30 Days per Refill) (*Initial Prescription is min. 3 months; max. refills 12*)

☐ 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: _____