eNeura

Please send completed form along with PATIENT DEMOGRAPHIC SHEET

Fax: 1-561-316-0224
Phone: 1-833-499-9300
Customercare@eneura.com

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:** _____