

Complete this form and fax with the patient's **medical chart face sheet** and **visit notes** to: 1 (877) 552-1753.

## Patient Information

Patient First Name \_\_\_\_\_ Patient Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Gender:  Female  Male  Non-binary

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

## Prescriber Information

Prescriber First Name \_\_\_\_\_ Prescriber Last Name \_\_\_\_\_

NPI Number \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

## Prescription

Diagnosis Code:  **M54.50**  **M54.51**  **M54.59**  Other \_\_\_\_\_  
(Select All That Apply) (Low Back Pain, Unspecified) (Vertebrogenic Low Back Pain) (Other Low Back Pain)

### Supporting Clinical Symptoms (Check all that apply)

- Diagnosis of chronic lower back pain (CLBP), documented in the clinical notes or below:
- Clinical Evaluation
  - Imaging showing degenerative changes or other chronic pathology
  - Documented pain scale rating  $\geq 4$  on a 10-point scale despite conservative treatments
- Prior and Current treatments (failed or contraindicated), documented in the clinical notes or below (Select all that apply):
- Physical Therapy  Opioid Pain Management  Injection Therapy
  - Non-Opioid Pain Management  Radiofrequency Ablation  Other: \_\_\_\_\_

### Prescribing Information

Item To Dispense: RelieVRx. Dispense: One VR Device. Dispense As Written. Length Of Need: 3 Months. Frequency Of Use: 1 Session Daily.

### Prescriber Authorization

I certify that the patient's record contains supporting documentation which substantiates the utilization and medical necessity of RelieVRx. I understand the indications for use and associated warnings and precautions of the RelieVRx product I have prescribed herein.

**Prescriber Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Patient Responsibility (Optional)

I hereby authorize AppliedVR to ship to me the RelieVRx product and agree to accept responsibility for payment for the RelieVRx program only if my out of pocket cost is:  **\$399** Or Less  **\$299** Or Less  **\$199** Or Less  **\$0**

I understand that a patient services representative from AVR Pathway will contact me with additional information about the program.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_