

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** _____

Prescriber Information

Prescriber First Name _____ **Prescriber Last Name** _____
NPI Number _____ **Prescribing Facility** _____
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 ≥ 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** _____