

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.

☐ Authorize up to 3 refills

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 _____