Leva PELVIC HEALTH SYSTEM | **Prescription Order Form** | **Fax to: (877) 800-4371** | Axena HEALTH

Healthcare Prescriber Information

***Prescriber First Name: _____ *Last Name: _____**

***Address: _____ *City: _____ *State: _____ * Zip: _____**

***Phone: ( )_____ *Fax: ( )_____ *Practice Name: _____**

Prescription

I am prescribing Axena Health's *Leva*® Pelvic Health System.

***Diagnosis & ICD-10 Codes (check all that apply): [ ]N32.81 Overactive Bladder [ ]R15.9 Fecal Incontinence**

[ ]39.3 Stress Incontinence [ ]N39.41 Urgency Incontinence [ ]N39.46 Mixed Incontinence

[ ] N81.84 Pelvic Muscle Wasting [ ]Other _____

Quantity: 1 with PRN replacements for 12 months If other, specify: _____

Directions for use:
Use twice daily (am & pm), approximately 2.5 minutes each time, following app training mode. Remove after each use.

If different directions for use apply, please indicate: _____

I certify I am the Prescriber identified on this form and authorized by law to order the product requested herein. I also certify the prescribed treatment is medically necessary, reasonable and appropriate according to accepted standards within the medical community for the treatment of the patient's diagnosed condition.

***Prescriber Signature (required): _____ *Date: ____/____/____**

Patient Information

***First Name: _____ *Last Name: _____ *DOB: ____/____/____**

***Mobile: ( )_____ *Phone: ( )_____ *Email: _____**

***Address: _____ *City: _____ *State: _____ * Zip: _____**

***Language Support: [ ]English [ ]Spanish [ ]Other: _____**

HCP Office Instructions

Please send the fully completed and signed *Leva* prescription order form either by fax to (877) 800-4371 or by email to fax@levacares.com.

Comments: _____

_____

If you have any questions, please call Axena Health at (866) 735-8423.

**Indicates required field.*