

Healthcare Prescriber Information

*Prescriber First Name: _____ *Last Name: _____
 *Address: _____ *City: _____ *State: _____ *Zip: _____
 *Phone: () _____ Fax: () _____ *Practice Name: _____

Prescription

I am prescribing Renovia’s leva[®] Pelvic Health System.

*Diagnosis & ICD-10 Codes (check all that apply): N32.81 Overactive Bladder R15.9 Fecal Incontinence N39.3 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 (morning & evening), approx 2½ minutes each time, following app training mode. Remove after use.

If different directions for use apply, please indicate: _____

I certify I am the Prescriber identified in this form and authorized by law to order the products 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: _____ *Date of Birth: _____ / _____ / _____
 *Mobile: () _____ *Phone: () _____ *Email: _____
 *Address: _____
 *City: _____ *State: _____ *Zip: _____
 *Language Support: English Spanish Other: _____

HCP Office Instructions

Please send the fully completed and a signed leva prescription either
 by fax [\(877\) 800-4371](tel:(877)800-4371) OR [\(877\) 974-6372](tel:(877)974-6372) or email fax@levatherapy.com

Comments: _____

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