NeuroSigma

Monarch eTNS® System
by NeuroSigma
external Trigeminal Nerve Stimulation for Attention Deficit Hyperactivity Disorder

Monarch Prescription Form

The information you provide will be used by NeuroSigma, its affiliates, and service providers for your patient's enrollment in the Monarch Pediatric Care Program. You may withdraw from the program any time. For more information, please call 424-248-3398.

Please fax or email completed forms to 310-479-3114 or orders@neurosigma.com

PATIENT INFORMATION

Patient First Name _____ Patient Last Name _____

Date of Birth _____ Gender _____

Parent/Caregiver Name _____ Relationship to Patient _____

Parent/Caregiver Phone _____ Alternate Phone _____

Address _____ City _____

State _____ Zip _____ Email Address _____

PRESCRIBER INFORMATION

HCP Name _____

Clinic Name _____ Clinic Contact _____

Address _____ City _____

State _____ Zip _____ Email _____

Phone _____ Fax _____

NPI _____ State License _____ Tax ID _____

PRESCRIPTION INFORMATION

☐ Monarch eTNS Starter Kit (comes with Monarch device and 4-week supply of disposable patches)

☐ Disposable electric patches (dispensed in packages of 7 – 1 week supply) Month(s) Supply = _____

DISPENSE AS WRITTEN – THERE IS NO SUITABLE ALTERNATIVE TO THE MONARCH OR PATCHES

I certify that the above device is medically necessary, and that the information provided is accurate to the best of my knowledge. By my signature, I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by the Monarch Pediatric Care Program to provide the offerings selected. I appoint the Monarch Pediatric Care Program, on my behalf, to convey this prescription to the dispensing pharmacy or durable medical equipment distributor of the patient's choice. I further certify that (a) any offering provided through this program on behalf of any patients not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use the Monarch Pediatric Care Program or any other product or service for anyone, and that (b) my decision to prescribe the products set forth on this page and request NeuroSigma Navigator Service offerings for my patient was based solely on my determination of medical necessity as set for herein, and that (c) I will not seek reimbursement for any offering provided by or through this service from any government program or third-part insurer.

Prescriber Signature_____ **Date** _____

CLINICAL INFORMATION

Diagnosis ☐ F90 ☐ F90.1 ☐ F90.2 ☐ F90.8 ☐ F90.9 ☐ Other ICD-10 Code _____

Please include copies of additional clinical documentation as necessary

AUTHORIZATION TO USE AND DISCLOSE MEDICAL INFORMATION

This Authorization allows my healthcare providers and my durable medical equipment or pharmaceutical suppliers (together, "healthcare providers") and health plans to disclose to NeuroSigma, Inc. and its third-party contractors, agents, and assignees (together, "NeuroSigma") protected health information ("PHI") about me related to my use or need for the products covered by the Monarch Pediatric Care Program. My PHI will include spoken or written facts, copies of my medical or other records from my healthcare providers, health plan or other sources outlining my medical history, treatment/management plan and other social determinants of health, as well as my insurance benefits and coverage information. The purpose of the disclosure and use set out above is to allow NeuroSigma to verify and/or obtain insurance coverage for the NeuroSigma products specified and to advise NeuroSigma with regards to the best form of communication to meet my needs. I understand that: (1) Once my PHI has been disclosed to NeuroSigma it may no longer be protected by federal privacy law and may be re-disclosed by NeuroSigma as a result. (2) I can refuse to sign this Authorization without impacting the start, continuation, or quality of my treatment, payment for treatment, clinic or insurance enrollment, or eligibility for insurance benefits or coverage because my healthcare provider and/or health plan cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization, but I will not be able to receive services from the Monarch Pediatric Care Program. (3) I may revoke, cancel or withdraw this Authorization at any time and for any reason by sending a signed written letter to the Monarch Pediatric Care Program at the following address: 45610 Woodland Road, Suite 320, Sterling, VA 20166. (4) If I cancel this Authorization, such cancellation will not change any actions that NeuroSigma or others took in reliance upon this Authorization before the date that I cancelled this Authorization. (5) This Authorization expires when my consideration for or participation in the Monarch Pediatric Care Program ends. (6) I have the right to receive a copy of this form from NeuroSigma. I give my permission to allow NeuroSigma to provide me with information about NeuroSigma products, disease education and awareness management programs, and promotional materials related to my condition or treatment.

Parent (or Patient's Representative) Signature _____ **Date** _____