MEDICAL ORDER
(CERTIFICATE OF MEDICAL NECESSITY)

This is a request for *Leva*® Pelvic Health System (HCPCS: S9002).

PATIENT INFORMATION REQUIRED

Patient Name (First & Last):		Date of Birth:
Patient Address (Street, City, State, Zip):		Patient Phone:
Patient Employer:	Patient E-mail:	
Primary Insurance:	Member ID:	Group ID:

PHYSICIAN OR OTHER PRESCRIBER INFORMATION

Physician Name:	NPI:
Practice Name:	Tax ID:
Practice (Mailing Address)	Phone Number:
Office Contact Name & E-mail:	Fax Number:

PRESCRIBER ORDER FOR *LEVA* PELVIC HEALTH SYSTEM (must be completed by prescriber or prescriber's staff)

DIAGNOSIS AND ICD-10 CODES

- ☐ N39.3 Stress Incontinence
- ☐ N39.41 Urgency Incontinence
- ☐ N39.46 Mixed Incontinence
- ☐ N32.81 Overactive Bladder
- ☐ R15.9 Fecal Incontinence
- ☐ Other _____

SUPPORTING CLINICAL SYMPTOMS (Check all that apply)

Leakage
- ☐ Leaking when coughing, sneezing, laughing
- ☐ Leaking w/ activities like lifting or exercising
- ☐ Post void leakage
- ☐ Leaking small drops
- ☐ Unable to hold in urine after feeling a sudden strong urge to urinate
- ☐ Leaking during sleep
- ☐ Leaking during sexual activity
- ☐ Incontinence pad use, visible wetness on garments
- ☐ Loss of solid stool
- ☐ Loss of liquid stool
- ☐ Incontinence of flatus

Urgency
- ☐ Frequent urination during the day
- ☐ Sudden, uncontrollable urges to urinate
- ☐ Waking up many times at night to urinate

Pelvic Health
- ☐ Post partum pelvic floor rehabilitation
- ☐ Pelvic floor muscle laxity
- ☐ **Other**

_____

Incontinence Related Quality of Life
- ☐ Decreased libido or sexual satisfaction
- ☐ Anxiety and / or depression
- ☐ Trouble sleeping / interrupted sleep
- ☐ Limits social interaction
- ☐ Limits exercise
- ☐ Odor associated with leakage

***Leva*® Pelvic Health System - 1st-line Pelvic Floor Muscle Training (PFMT) treatment and monitoring for urinary or fecal incontinence.**

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 _____ **DATE:** _____

OFFICE INSTRUCTIONS. IN ADDITION TO THIS CMN, PLEASE ATTACH INSURANCE AND SUPPORTING CLINICAL NOTES.

Please send the fully completed and signed *Leva* prescription order form by Fax: 877-800-4371 or Email .pdf file: fax@levacares.com