SPINALOGIC®

enovis™

Bone Growth Stimulator Prescription and Medical Necessity Form

Patient Name (Beneficiary Name)				Home #
Address				Work #
City	State	Zip	Birth Date	Sex
Prescriber's Full Name	Office Contact		Phone #	
Physician NPI#			Fax #	

INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Name of Insured	Birth date	Name of Insured	Birth date
SSN	Relation to Patient	SSN	Relation to Patient
Policy / Claim No.	Subscriber / ID No.	Policy / Claim No.	Subscriber / ID No.
Insurance Co. Phone #	Contact	Insurance Co. Phone #	Contact
Employer of Insured		Phone #	Contact

FOR MEDICARE PATIENTS ONLY (Required) NOTE: Prescribers full name and NPI# required above

Emergency Point of Contact	Phone #
Length of Need	ICD-10 Diagnosis Code(s)
Medicare Beneficiary Identifier (MBI#)	

MEDICAL SUMMARY (To be completed by the prescribing individual only)

ORDER DATE (REQUIRED): ______________________________

LENGTH OF NEED: ______________________________

Primary Diagnosis

- ❑ Degenerative Disc Disease
- ❑ Internal Disk Disruption
- ❑ Herniated Nucleus Pulposus
- ❑ Lumbar Instability
- ❑ Low Back Pain
- ❑ Scoliosis
- ❑ Spondylosis
- ❑ Spondylolisthesis / Grade __________
- ❑ Spinal Stenosis
- ❑ Radiculopathy
- ❑ Other ______________________________

Date of Injury __________ / __________ / __________

ICD-10 Diagnosis Code(s) ______________________________

Narrative Diagnosis ______________________________

Planned Procedure:

Date __________ / __________ / __________

Fusion Surgery ______________ **to** ______________

Other ______________________________

Prior Procedure(s)	Date	Levels
❑ Fusion Surgery	_______/_______/_______	_________to _________
❑ Discectomy	_______/_______/_______	_________to _________
❑ Laminectomy	_______/_______/_______	_________to _________
❑ Other	_______/_______/_______	_________to _________

____

Comorbidities that apply (Check any applicable):

❑ Multi-Level Fusion	❑ Obesity	❑ Diabetes
❑ Mixed Graft	❑ Tobacco use (_______ppd)	❑ Arthritis
❑ Allograft	❑ Failed Fusion	❑ Alcohol Use
❑ Autograft	❑ Osteoporosis	❑ Spondylolisthesis
❑ Advanced Age	❑ History of smoking	❑ Vascular disease
❑ Renal Disease	❑ Long term steroid use	❑ NSAIDS
❑ Previous Back Surgery	❑ Stenosis	

❑ Other ______________________________

PLEASE READ AND SIGN BELOW: I understand the Food and Drug Administration has approved the SpinaLogic Bone Growth Stimulator (SpinaLogic) to use as an adjunct treatment to primary lumbar fusion surgery for one or two levels. I acknowledge that DJO, LLC, has not promoted SpinaLogic to me for any other use or otherwise encouraged me to order it for any other use. I specifically desire to order the SpinaLogic, which is only available directly from DJO, LLC, so that I may treat the patient in question according to my informed medical judgement. By my signature below, I am prescribing the bone growth stimulator device listed above. In my judgement, the above-prescribed item is medically indicated and necessary, and consistent with current accepted standards of medical practice and treatment of this patient's physical condition.

X Prescriber's Signature **Date**

DISPENSE AS WRITTEN (no substitutions without authorization from prescribing individual) Please retain a copy for your records

SALES REPRESENTATIVE NAME / TITLE (PRINT) / REP # SIGNATURE REPORTING CLINIC # (REQUIRED) DATE

INSTRUCTIONS FOR USE:

1. Place device over treatment site 2. To begin treatment, press and release the power button until it beeps 3. Wear the device for 30 min. to complete daily treatment.