Medical Prescription

Calm. Confidence. Control.

PRESCRIBING REQUIREMENTS AND CONSIDERATIONS FOR MEDICAL NECESSITY.

Thank you for your interest in ZIDA Wearable Neuromodulation System, intended to treat patients with an overactive Bladder (OAB) and associated symptoms of urinary urgency, urinary frequency, and urge incontinence.

To prescribe the Zida System for your patient the following documents should be completed and sent to Zida:

1. Zida Control Sock: Standard Written Order – Prescription Form
2. Medical Necessity Form
3. Patient-signed intake form
4. Electronically signed chart notes with patient name and date of birth, that includes diagnoses, behavior modification approaches tried and failed and medications tried and failed, as well as any side effects experienced by the patient.
5. A copy of the front and back of the insurance card
6. Any other documentation that may be relevant to the patient's diagnosis.

After receiving all the above completed documents, our team is committed to providing patients the support they need throughout their treatment journey, from submitting reimbursement to using the Zida system. If you or your staff have any questions or concerns about your patient's Zida prescription, please do not hesitate to contact our Customer Support team at 877-203-1580 or email us at info@livezida.com.

We look forward to working together to provide the best possible care for your patient.

Zida is indicated to treat patients with an overactive Bladder (OAB) and associated symptoms of urinary urgency, urinary frequency, and urge incontinence.

Caution: Federal law restricts this device to sale by or on the order of a physician. Before use, refer to the Zida user guide for complete product instructions for use, contraindications, warnings, and precautions that can be found in the box that comes along with the Zida system as well as on our website at livezida.com

Submit completed forms via:
Fax: (833) 599-2554 | Encrypted Email: info@livezida.com | Secure Zida Customer Support: 877-203-1580
5663 Lick River Lane Gainesville VA 20155

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PATIENT INFORMATION

NAME: (required)	GENDER:	
DATE OF BIRTH:	SPANISH SPEAKING ONLY ☐	
ADDRESS:	EMAIL: (required)	
CITY:	STATE:	ZIP:
PHONE:	SECONDARY INSURANCE:	

START DATE: (required) _____

PRESCRIBED PRODUCT ZIDA CONTROL SOCK

PRIMARY ICD-10 DIAGNOSIS: (required)

ICD-10 N32.81 Overactive Bladder
☐ Primary ☐ Secondary

ICD-10 R32- Unspecified Urinary Incontinence
☐ Primary ☐ Secondary

ICD-10 R35.0 Frequency of Micturition
☐ Primary ☐ Secondary

ICD-10 R39.41 Urge Incontinence
☐ Primary ☐ Secondary

ZIDA CONTROL KIT COMPONENTS:

- ☑ Zida Control Sock-E0736
- ☑ Zida Control Unit-E0731
- ☑ AAA battery
- ☑ Zida User Guide
- ☑ 2 oz tube of conductive gel-A4558

SOCK SIZING CHART

SIZE	US WOMANS	US MENS	EURO
☐ Small	4-6.5	3-5.5	34-37
☐ Medium	7-9.5	6-8.5	38-41
☐ Large	10-12.5	9-11.5	42-45
☐ X-Large		12-14.5	46-49

TREATMENT FREQUENCY:

-Conduct 12 treatments, typically once per week.

-After the initial 12 treatments, slowly increase the time between treatments, closely monitor for the return of symptoms.

-If symptoms reappear or increase in severity, the patient's treatment schedule should revert to the last previously effective treatment schedule.

CLINICIAN INFORMATION

NAME: (required)	LICENSE #	NPI
CREDENTIALS:	EMAIL:	
ADDRESS:	PHONE:	
CITY:	STATE:	ZIP:
RN/MA CONTACT NAME:	ZIDA is a Nueromodulation System that is inteded to treat patients with an overactive Bladder (OAB) and associated symptoms of urinary urgency, urinary frequency, and urge incontinence.	

In the event that the patient is receiving a free sample the provider will not bill the patient's insurance company for that product.

DATE: (required) _____ SIGNATURE: (required) _____

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MEDICAL NECESSITY FORM

Did the patient try and fail a behavior modification approach for urinary incontinence?
Please check all that apply:

- ☐ Bladder Training: Attempt to train the patient to urinate at preset intervals
- ☐ Urge Suppression Strategies: Deep breathing and relaxation exercises to resist the urge at the wrong times
- ☐ Diet: Limiting or refraining from alcohol, coffee, tea, and/or soda; staying away from foods that cause excessive urination
- ☐ Exercise: Kegel exercises and other pelvic floor exercises to strengthen the bladder muscles

Did the patient try and fail medication for urinary incontinence?
Please check all the apply; at least two classes of medications are preferred:

Antidepressants	Anticholinergics	Beta-3 adrenergics	Hormones	Antimuscarinics	Antispasmodics
☐ Duloxetine: Cymbalta ☐ Desipramine: Norpramine ☐ Imipramine: Tofranil	☐ Oxybutynin (Ditropan XL) ☐ Tolterodine (Detrol) ☐ Solifenacin (Vesicare) ☐ Fesoterodine (Toviaz)	☐ Vibegron (Gemtesa) ☐ Mirabegron (Myrbetriq)	☐ Estradiol cream (Estrace) ☐ Conjugated estrogen cream (Premarin)	☐ Darifenacin (Enablex) ☐ Trospium Chloride	☐ Propiverine

Has the patient experienced any side effects to any of the above medications?
Please list below if the patient took any medication or other steps to counteract the side effects.

_____

_____

_____

Is the patient clinically unable to try the medications listed above?
If yes, please explain why the patient is unwilling to take the medication(s).

_____

_____

_____

Are you, as the prescriber, unwilling to prescribe one of the above-listed medications to the patient?
Please give further details.

_____

_____

_____

IMPORTANT: Please ensure that the behavior modification approaches tried and failed and medications tried and failed, as well as any side effects experienced by the patient are are all included in the chart notes.