# Medical Prescription

## 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.**

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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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Calm. Confidence. Control.

## 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<br>☐ Desipramine: Norpramine<br>☐ Imipramine: Tofranil | ☐ Oxybutynin (Ditropan XL)<br>☐ Tolterodine (Detrol)<br>☐ Solifenacin (Vesicare)<br>☐ Fesoterodine (Toviaz) | ☐ Vibegron (Gemtesa)<br>☐ Mirabegron (Myrbetriq) | ☐ Estradiol cream (Estrace)<br>☐ Conjugated estrogen cream (Premarin) | ☐ Darifenacin (Enablex)<br>☐ 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.

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## PATIENT INTAKE FORM

### Patient Acknowledgements and Acceptance of Financial Responsibility from Zida's prescription form:

### PATIENT ACKNOWLEDGEMENTS

a. I authorize Zida and its staff to provide me with durable medical equipment prescribed by my healthcare professional (HCP). My HCP has explained the nature of this treatment, and I have received sufficient information about the ZIDA Wearable Neuromodulation System to make an informed decision.

b. I authorize the release to ZIDA of any medical records for payment purposes, including but not limited to processing insurance claims. I also authorize ZIDA to share my medical records for healthcare operations and treatment purposes, including but not limited to sharing Zida Neuromodulation therapy data with my prescribing HCP.

c. My HCP has screened me for the appropriateness of Zida Neuromodulation Therapy. I do not have a cardiac pacemaker or implanted defibrillator and I am not pregnant. I understand the device should not be used on swollen, infected, inflamed areas, skin eruptions, open wounds, or cancerous lesions. I will alert my HCP and Zida if my health condition changes such that therapy use is now contraindicated.

d. My HCP has explained the nature of this treatment, and I have received information about the ZIDA Wearable Neuromodulation System and its appropriate and safe use. Upon receipt of my device, I understand that training is available to me by a Zida Customer Care Representative. I shall contact Zida Customer Support at 877-203-1580.

e. I take full responsibility for the safe use and care of the Zida Neuromodulation Therapy System which includes the Zida Control Sock and Zida Device. I will advise my HCP before discontinuing treatment or using the equipment. I shall not hold Zida responsible for any adverse consequences related to any misuse, failure to use, or discontinuation of the treatment. Zida maintains customer support by telephone at 877-203-1580.

f. Medicare Beneficiary: I understand the products and/or services provided by Zida are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-D/section-424.57. Upon request, I will be furnished with a paper copy of the standards.

g. Results Not Guaranteed: My HCP has prescribed Zida Neuromodulation Therapy System to deliver electrical stimulation to relieve symptoms of overactive Bladder (OAB) and associated symptoms of urinary urgency, urinary frequency, and urge incontinence. I understand that this is not a cure for overactive Bladder (OAB) and associated symptoms of urinary urgency, urinary frequency, and urge incontinence. I also understand that individual patient results may vary, and no warranty or guarantee is made regarding my use of the Zida Neuromodulation Therapy System. I understand Zida control sock is intended for single patient use only and is provided with an initial six-month supply that must be replaced.

h. Return of Device to Zida: I understand that I cannot return any component of Zida Neuromodulation Therapy System, refunds and returns will be accepted in accordance with Medicare guidance.

i. Any deductible and/or out-of-pocket expenses are collected upon receipt of the Explanation of Benefits issued by the insurer as defined by the cost identified in the patient responsibility section of the EOB.

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### PATIENT FINANCIAL RESPONSIBILITIES

a. I assign to Zida or the company's designated representative all rights, benefits, and payments to which I am entitled under any benefit plan or insurance for items and services furnished to me or my dependents by Zida.

b. Accepting items and services from Zida or the company's designated representative means accepting my responsibility for any deductible, copay, and remaining balance due. I authorize Zida to inquire about, submit and appeal claims to my insurance for items and services received from Zida.

c. I authorize Zida or the company's designated representative to submit claims to my insurance on my behalf and my insurance to pay benefits directly to Zida. If I receive funds intended to pay, in whole or part, the forgoing claims, I will immediately pay over such funds to Zida or the company's designated representative to apply to any balance due.

d. I may revoke this authorization in writing to Zida. I assign Zida any legal or administrative claim or cause of action, including fiduciary duty claims, arising from any benefit plan or insurance concerning medical expenses incurred from items or services received from Zida.

e. I will promptly notify Zida of any changes to my insurance.

f. I accept full and complete financial responsibility for all charges for any or all components of the Zida Neuromodulation Therapy System that are not covered by my insurance or for which I am responsible for payment under my insurance. Zida accepts VISA, MasterCard and American Express for payment.

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

| | |
|---|---|
| NAME: | DATE OF BIRTH: |
| DATE: | SIGNATURE: |