

**This section may be completed by Bioventus**

|                         |        |        |      |
|-------------------------|--------|--------|------|
| Patient Name: First     | MI.    | Last   |      |
| Street Address:         | City:  | State: | Zip: |
| Patient DOB: MM/DD/YYYY | Phone: |        |      |

**This section MUST be completed by practitioner/staff**

|                                                                                                                                                                                                                                                                                                       |                                           |                                     |                                                          |                                       |                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------|----------------------------------------------------------|---------------------------------------|--------------------------------------|
| Primary Diagnosis (mark all that apply):                                                                                                                                                                                                                                                              |                                           |                                     |                                                          |                                       |                                      |
| Pain _____<br>ICD-10 code                                                                                                                                                                                                                                                                             | Pain, not classified _____<br>ICD-10 code | Other _____<br>ICD-10 code          |                                                          |                                       |                                      |
| Location: <input type="checkbox"/> Shoulder                                                                                                                                                                                                                                                           | <input type="checkbox"/> Arm              | <input type="checkbox"/> Elbow      | <input type="checkbox"/> Wrist                           | <input type="checkbox"/> Hand/Fingers | <input type="checkbox"/> Unspecified |
| <input type="checkbox"/> Hip                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Knee             | <input type="checkbox"/> Ankle/Foot | <input type="checkbox"/> Leg/Thigh                       |                                       |                                      |
| Functional Limitations:                                                                                                                                                                                                                                                                               |                                           |                                     |                                                          |                                       |                                      |
|                                                                                                                                                                                                                                                                                                       |                                           |                                     |                                                          |                                       |                                      |
| Patient's Need (mark all that apply):                                                                                                                                                                                                                                                                 |                                           |                                     |                                                          |                                       |                                      |
| <input type="checkbox"/> Pain Reduction, localized                                                                                                                                                                                                                                                    |                                           |                                     | <input type="checkbox"/> Improve Functional Capabilities |                                       |                                      |
| <input type="checkbox"/> Reduce Dependency on Oral Medications                                                                                                                                                                                                                                        |                                           |                                     | <input type="checkbox"/> Other (explain)                 |                                       |                                      |
| Length of Need:                                                                                                                                                                                                                                                                                       |                                           |                                     | Prognosis:                                               |                                       |                                      |
|                                                                                                                                                                                                                                                                                                       |                                           |                                     |                                                          |                                       |                                      |
| Physician's Signature:                                                                                                                                                                                                                                                                                |                                           |                                     | Date:                                                    |                                       |                                      |
| <i>State law requires renewal on said item every 12 months. Length of need is dictated based on state standard of 1 year unless indicated above. I certify that the above-prescribed equipment is medically indicated and in my opinion is reasonable and necessary for this patient's treatment.</i> |                                           |                                     |                                                          |                                       |                                      |

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| PHYSICIAN INFORMATION |  |                 |        |
|-----------------------|--|-----------------|--------|
| Physician:            |  | License #:      | NPI #: |
| Address:              |  | Phone:          | Fax:   |
| City, State, Zip:     |  | Office Contact: |        |

**Upon completion, fax this form to Bioventus Customer Service Department  
 Fax: 661.310.9623 | Email: PNSorders@Bioventus.com | Phone: 888.453.2136**

The StimRouter Neuromodulation System is indicated for pain management in adults who have severe intractable chronic pain of peripheral nerve origin, as an adjunct to other modes of therapy (e.g., medications). The StimRouter is not intended to treat pain in the craniofacial region.

Do not use the StimRouter Neuromodulation System in users who have an implanted demand cardiac pacemaker, implanted cardioverter defibrillator (ICD), or other implanted active device, or who have bleeding disorders that cannot be stopped in advance of the StimRouter implantation procedure. Do not use the system where a metallic implant or a cancerous lesion is present in the immediate implant area. Effects of stimulation during pregnancy are not known. StimRouter is capable of producing skin irritation and muscle ache in the area of stimulation.