canvas Dx™

canvasdx.com

canvas Dx™

Pediatric Autism Spectrum Disorder Diagnosis Aid

Prescription Form

866-4COGNOA
connect@cognoa.com

FAX all prescriptions to Orsini Specialty Pharmacy at 877-810-7806

PATIENT INFORMATION

Patient First Name ______________________ MI _____ Last Name ______________________

Date of Birth ______________________ Gender at Birth: ❑ Male ❑ Female

Address ______________________ City ______________ State ________ Zip ________

CAREGIVER INFORMATION

Caregiver First Name ______________________ MI _____ Last Name ______________________

Home Phone ______________________ Mobile Phone ______________________

Email ______________________ Caregiver Relationship ______________________

PRESCRIBER INFORMATION

Prescriber First Name ______________________ MI _____ Last Name ______________________

Address ______________________ City ______________ State ________ Zip ________

Phone ______________________ Fax ______________________

Prescriber Email ______________________ Office/Practice Name ______________________

Office Contact Name ______________________ Office Contact Email ______________ Phone ________

Prescriber Direct Message Address (If Available) ______________________

PATIENT'S INSURANCE INFORMATION (May be faxed separately)

Patient Uninsured? ❑ YES ❑ NO

PRIMARY INSURANCE

Insurance Name ______________________

Customer Service Phone ______________________

ID # ______________________

Group # ______________________

BIN # ______________________

PCN # ______________________

SECONDARY INSURANCE

Insurance Name ______________________

Customer Service Phone ______________________

ID # ______________________

Group # ______________________

BIN # ______________________

PCN # ______________________

PRESCRIPTION & CLINICAL INFORMATION

Diagnosis (ICD-10 Code): ______________________

❑ **Canvas Dx** pediatric autism spectrum disorder diagnosis aid

Instructions for Use: Complete all steps as directed in the Canvas Dx App

Dispense: One access code good for 90 days of use

Refills: ________ ❑ May substitute ❑ Dispense as Written

Prescriber Certification

I am currently a licensed and qualified healthcare professional and have the authority under applicable state laws to prescribe Canvas Dx and to evaluate the device output as part of my clinical assessment of the minor patient identified above, and my prescription for Canvas Dx is medically necessary for the patient, and the information provided above is accurate to the best of my knowledge. I understand that Cognoa's contracted pharmacy(ies), its agents and affiliates, and their respective employees (collectively, "Pharmacy") will use the information on this prescription form to process the prescription, verify insurance coverage and benefits for the patient/caregiver, bill the insurance and/or patient's caregiver named above, and share certain information with the manufacturer of Canvas Dx, or Cognoa, Inc. ("Cognoa"), in order to enable fulfillment of the prescription, use of the Canvas Dx device, and customer services and technical support associated with the prescription and use of Canvas Dx. The Pharmacy may also administer any co-pay assistance programs that may provide financial assistance to patients who meet certain eligibility criteria.

By my signature, I also certify that my patient and his/her caregiver, as designated above, have provided a signed HIPAA authorization that allows me to share Protected Health Information with Pharmacy and Cognoa for purposes of fulfilling this prescription and of enabling Cognoa to generate and provide the device output, develop and improve its products and services, and provide customer service and technical support to the caregiver.

A copy of the FDA-approved labeling, including the Instructions for Use and qualification requirements for the intended user of Canvas Dx, has been made available to me at CanvasDx.com, and I understand that Canvas Dx is intended only as an adjunct to my clinical diagnostic process and should be used in conjunction with the clinical presentation of the patient, at my sole discretion, and pursuant to my independent medical judgment.

In addition, I understand that as a condition to my use of Canvas Dx I agree to be bound by the Cognoa Canvas Dx Healthcare Provider Terms and Conditions, a copy of which is available to me at CanvasDx.com.

X Prescriber Signature ______________________ **Prescriber NPI Number** ______________ **Date** ____________