theranica

Nerivio® Direct

Patient

Name: _____ Email: _____@_____

Phone: _____DOB: _____ Address _____

City: _____ State _____ Zip: _____

Rx : Nerivio **Quantity:** ___

Refills: 12 ☐ 24 ☐ Other: _____

Directions: Apply one 45-minute treatment within 60 minutes of migraine onset.

Health Care Provider Signature: _____

Date:_____

Health Care Provider Name: _____NPI: _____

Address:_____

City: _____ State:_____ Zip: _____

Telephone: _____ Fax: _____

Once filled and signed by a licensed HCP, this form should be faxed from the clinic office fax to Quick Care

QuickCare
COMPREHENSIVE PHARMACEUTICAL SERVICES

9397 Haven Ave
Rancho Cucamonga CA, 91730
Phone: 866-393-8116, option 9
Fax: 866-393-5258