Fisher Wallace Stimulator®

Information for Your Provider

FDA CLEARED | BBB A+ rating | MADE IN USA | HSA/FSA ELIGIBLE

USAGE GUIDELINES AND AUTHORIZATION FORM

The Fisher Wallace Stimulator® is a wearable, safe neurostimulation device that is FDA-Cleared to treat depression, anxiety and insomnia.

Who May Authorize Patient Purchase: A healthcare practitioner licensed in the state that he or she practices.

FDA-Clearance Date: 1990
Medicaid Approval Date: 2017

USAGE GUIDELINES

The Fisher Wallace Stimulator® should be used for 20 minutes, twice-a-day (morning and evening). Patients with insomnia should use the device within two hours of bedtime.

If mood and sleep symptoms are reduced but do not go into remission within the first 30 days, patients may continue using the device on a daily basis.

If mood and sleep symptoms go into remission, patients may use the device on a "maintenance basis" three to four times per week, or on an "as needed basis."

The device may be safely used in conjunction with drug therapy (such as antidepressants) or as a standalone therapy.

The device has been on the market since 1990 without reports of negative effects from long term use.

Discontinuing use of the device does not cause withdrawal symptoms.

CONTRAINDICATIONS

Patients with pacemakers, implanted stimulators, or any other implanted electronic medical device should not use the Fisher Wallace Stimulator®.

POTENTIAL SIDE EFFECTS

Temporary headache and dizziness occur in less than 1% of patients. These symptoms dissipate shortly after terminating use of the device.

Patients may return their device for a refund within 30 days of receipt, and may request an additional 30 days (60 days total) as needed.

CALL FISHER WALLACE WITH ANY QUESTIONS: (800) 692-4380

A PRESCRIPTION PAD MAY BE SUBSTITUTED FOR THIS FORM

AUTHORIZATION FORM FOR THE FISHER WALLACE STIMULATOR®

Date:_____ /_____ /_____

Practitioner's Information

Practitioner's Name: _____

Practitioner's Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Email: _____

State License Number: _____

I authorize the following patient to purchase the Fisher Wallace Stimulator®:

Patient's Information

Patient's Name: _____

Patient's Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____

HCPSC Code: E1399

Diagnosis Code(s): _____ Practitioner's signature _____

Fax completed form to (800) 657-7362

OR

Email a photo of completed form to info@fisherwallace.com