

Prescription/Letter of Medical Necessity for **Contiform® Self-Inserted Urethral Support Device (Pessary)**

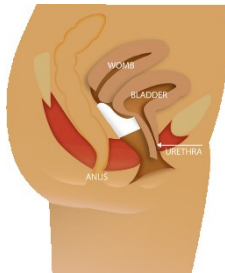
Attention Dr. _____

Prescription/Letter of Medical Necessity, your patient wishes to purchase the **Contiform® Self Inserted Bladder Support Device (pessary)** to control her **bladder leakage (stress urinary incontinence)**.

She needs this form for **insurance** purposes as the product is covered by private insurance plans unlike disposable pads and diapers. Canadian women can have access to a clinically effective device that is covered by their private insurance, many provincial disability reimbursement programs and federal reimbursement programs for veterans and first nations.

What is a Contiform®?

- An intra-vaginal urethral support device (pessary)
- For SUI (stress urinary incontinence) has also shown to help rectocele.
- Can be worn for 24 hours and is approved for up to 5-day continuous wear.
- If a woman has grade 2 prolapse or less and can still retain a tampon, then Contiform® will stay in place and help stop bladder leaks.
- **Contiform® has been clinically shown** to be very effective in immediately stopping bladder leaks by helping keep the urethra closed preventing SUI.
- It is safe and easy to use, and the bestselling self-fitted pessary in the UK, EU and Australia.
- Can be used after first trimester of pregnancy and 6 weeks post-delivery.
- *Not recommended for women with cystocele, during sexual intercourse or for use with tampon or menstrual cup.



If you have any questions, please contact **ActivKare** at tel: 1-855-811-3733. For more detailed information on **Contiform** or to see a short product video visit <https://activkare.com/group/women/>



PRESCRIPTION/LETTER OF MEDICAL NECESSITY
SELF INSERTED BLADDER SUPPORT DEVICE
(PESSARY) FOR THE TREATMENT OF STRESS
URINARY INCONTINENCE (SUI)

Instructions:

- 1) This form is for the Contiform® Bladder Support device (pessary).
- 2) Please have this form completed by your physician.
- 3) Physician, please complete all blanks and maintain the original in patient's file.

I have prescribed/recommended the Contiform® Intra-Vaginal Device for SUI as needed and described herein. It is my expert opinion that the Contiform® device for SUI is medically necessary to facilitate management of this patient's urinary function. This recommendation shall also serve as the Certificate of Medical Necessity.

Estimated Length of Need (# months): (99 = Lifetime) _____ months

Products to order: 3 size starter kit contains (small, medium, large) **Check box**
Single size unit (after self-sizing is determined) **Check box**
Replacement Silicone Ribbon (to remove pessary) **Check box**

Physician Information (or nurse continence advisor)

Physician name: _____
Physician Address: _____
Physician Tel #: _____
Physician Fax #: _____ E-mail address: _____
Physician License #: _____ Physician signature: _____ Date: _____

Patient Information:

Name: _____ Date of Birth: _____
Address: _____
Patient Phone: _____

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