Rx PHYSICIAN'S PRESCRIPTION

Date of Placement: _____ / _____ / _____

Patient's Name: _____ ☐ Surgical ☐ Non-surgical

I am prescribing a Vasopneumatic Compression and Cold Therapy System (**Game Ready**™) due to my patient's needs and diagnosis. I certify that the **Game Ready**™ device is medically indicated and in my opinion is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition.

Product:
- ☐ **GAME READY™ Control Unit, complete with heat exchanger and Wrap**
- ☐ **Manual Cryotherapy Device : Aircast Cryo-Cuff Cryotherapy System**
- ☐ **Continuous Flow Cryotherapy System:** ☐ Ossur Cold Rush ☐ DJO Iceman ☐ Breg Kodiak

Wrap Required: ☐ Knee ☐ Articulated Knee ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Ankle ☐ Back ☐ Hip

Side Treated: ☐ Right ☐ Left

Rx PHYSICIAN'S LETTER OF MEDICAL NECESSITY

I am writing on behalf of my patient that you approve coverage for the **Game Ready**™ vasopneumatic compression and cold therapy system. I consider this device medically necessary and I am prescribing this device for the purpose of musculoskeletal injury treatment and/or post-operative treatment.

The **Game Ready**™ System combines cold and compression therapies. It is intended to treat post-surgical and acute injuries to reduce edema, swelling and pain where cold and compression are indicated.

RICE (Rest, Ice, Compression, Elevation) has long been used to treat acute and chronic injury and assist in rehabilitation following orthopedic surgery. **Game Ready**™ combines the two most difficult-to-manage aspects of the RICE regimen (Ice and Compression) by offering adjustable cold and intermittent compression to all major joints.

The anatomically-designed wraps are engineered for all major body parts and utilize intermittent compression and fluid circulation technology, simultaneously delivering circumferential cold and compression.

My post-operative and rehabilitative care plan calls for the use of the **Game Ready**™ device to reduce pain and swelling. Failure to control pain not only causes unnecessary suffering but can delay my patient's recovery. Therefore, need for compliance with the required treatment is high. I certify that the above-described product is medically indicated and in my opinion is reasonable and necessary. Given the safety and effectiveness of this unit, I prescribe and recommend that the patient use this device daily. Without use of this device there is potential to cause unnecessary delay in the patient's recovery.

If you have any questions, please feel free to contact my office directly.

Physician Signature: _____ Date: _____ / _____ / _____

Physician Printed Name: _____ Reg'n: _____

Physician Telephone Number: _____