PATIENT REIMBURSEMENT & SUPPORT CENTER

PRESCRIPTION FORM

Phone: 888.514.7828 • Fax: 877.591.2505

1—STEP ONE: Complete Patient and Insurance Information

Patient First Name ______________ Last Name ______________ Middle Initial ______ Allergies: [ ] NKDA [ ]

DOB ______________ SSN# ______________ ❑ Male ❑ Female

Address ______________ City ______________ State ______ Zip ______

Phone (Home) ______________ (Work) ______________ (Cell) ______________ Email (Optional) ______________

Primary Insurance______________ Policyholder ______________ Relationship to Cardholder ______________

Policy # ______________ Group # ______________ Phone # ______________

Secondary Insurance______________ Policyholder ______________ Relationship to Cardholder ______________

Policy # ______________ Group # ______________ Phone # ______________

Prescription Drug Insurer ______________ ID # ______________ Group # ______________Phone # ______________

2—STEP TWO: Diagnosis and Medical Information

❑ ICD-9 528.00 Stomatitis and mucositis unspecified
❑ ICD-9 528.01 Mucositis due to antineoplastic therapy such as
  ❑ E930.7 Antineoplastics ❑ E933.1 Immunosuppressives ❑ E879.2 Radiation therapy
❑ ICD-9 528.02 Mucositis due to other drugs
  ❑ E___________ other therapy
❑ ICD-9 528.79 Other disturbances of the oral epithelium including tongue

Type of Cancer: [ ] ICD-9: [ ]

Other Diagnosis: [ ] ICD-9: [ ]

3—STEP THREE: Read and Sign Patient Authorization

By signing this Authorization, I authorize my health plans, physician, and pharmacy providers to disclose my Protected Health Information ("PHI"), including, but not limited to, information relating to my medical condition, medical history, treatment, care management, and health insurance, as well as all information provided on this form and any prescription, to the MuGard™ Patient Reimbursement and Support Center, its representatives, agents, and contractors (collectively "MuGard™ Patient Center") to be used and disclosed for the following purposes: (1) to establish my eligibility for benefits for the coverage of MuGard™; (2) to obtain any authorization or precertification for the coverage of MuGard™, (3) to communicate with my health care providers, including pharmacy providers, and me about my medical care; (4) to facilitate the provision of MuGard™ by a third party pharmacy including specialty pharmacies ; and (5) to prepare and provide reports, excluding PHI provided that the de-identification complies with the requirements set forth in 45 CRF 164.514(b), to the manufacturer of MuGard™ regarding my health insurance coverage and reimbursement for MuGard™ prescriptions in general. My authorization applies to any PHI governed and protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, and under the rules and regulations thereunder.

I understand that my PHI used or disclosed under this authorization may be re-disclosed by the person(s) or class of person(s) receiving it and is no longer protected by Federal privacy laws. I understand that my health care providers and insurance company will not condition my medical treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits on my signing of this authorization. I understand, however, that if I do not sign this authorization, I will not be eligible to receive assistance through the MuGard™ Patient Center. I understand that I am entitled to a copy of this Authorization. I understand that I shall be contacted by the MuGard™ Patient Center as part of the assistance process, and that I may also be contacted by the MuGard™ Patient Center to conduct a Satisfaction Survey. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to The MuGard™ Patient Center, 23230 Chagrin Boulevard, Suite 550, Beachwood, OH, 44122; but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization expires three (3) years from the date signed below. I understand that I may call the MuGard™ Patient Center's toll-free number 888-514-7828 at any time.

REQUIRED: **IF APPLICABLE:**

______________ Print Name of Patient ______________ Signature of Patient ______ Date ______________ Print Name of Personal Representative ______________ Signature of Personal Representative ______ Date

4—STEP FOUR: Prescription Information

Medication	Dose	Directions	Quantity	Refills
MuGard™	5 - 10 ml	Swish and expel or swallow 4 - 6 times daily as prescribed for relief of Oral Mucositis	____ 6 pk(s) (8 oz bottles)	

Prescriber's Signature ______________ Date ______________
(Required to process prescription – stamped signatures are not permissible)

5—STEP FIVE: Physician Contact

Deliver to: ❑ Patient's Home ❑ Physician's Office

Ordering Physician First Name ______________ Last Name ______________ Institution______________

Physician's Address ______________ Suite ______ City ______________ State______ ZIP________

Office Contact ______________ Phone ______________ Fax ______________

Specialty ______________ License # ______________ DEA # ______________ NPI #______________

Prescriber (If different than physician) First Name ______________ Last Name ______________ NPI #______________

Manufacturer Rep ID:______________