Oral Mucositis Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

OralMucoRX-20-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ K12.30 Oral mucositis (ulcerative) unspecified
☐ K12.31 Oral mucositis (ulcerative) due to antineoplastic therapy
☐ K12.32 Oral mucositis (ulcerative) due to other drugs
☐ K12.33 Oral mucositis (ulcerative) due to radiation
☐ K12.39 Other oral mucositis (ulcerative)
☐ K13.29 Other disturbances of oral epithelium, including tongue

Type of Cancer:_____
ICD-10:_____

Other Diagnosis:_____
ICD-10:_____

History of therapies tried/failed and reason for discontinuation (please include dates):

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **MuGard®** (oral mucoadhesive)	☐ 5 – 10 ml	Swish and expel or swallow 4 to 6 times daily as prescribed for the management of oral mucositis	_____ Number of 8 oz bottles	
☐ **Gelclair®** (bioadherent oral gel)	☐ 15 ml	Rinse with 15 mL (1 packet mixed with 1 tablespoon of water) 3 times daily	_____ Number of single-use packets	

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ / ____ / ____