

# ProThelial Prescription Referral & Refill Form

(HIPAA Compliant)

**Patient & Prescriber to Sign Form, Then Fax to 1-860-477-0962**

## 1. PATIENT AND INSURANCE INFORMATION

Patient Name: \_\_\_\_\_ Gender: **M**  **F**  Patient's Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Patient's Full Address: \_\_\_\_\_ POLICY HOLDER's Full Address: \_\_\_\_\_  
 Primary Insurance: \_\_\_\_\_ NAME POLICY HOLDER: \_\_\_\_\_ Their Date of Birth \_\_\_\_\_ Their Phone: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Group Policy Number : \_\_\_\_\_ Subscriber ID or Rx BIN Number: \_\_\_\_\_  
**Secondary Insurance:** \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Their Date of Birth \_\_\_\_\_ Their Phone: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Group Policy Number : \_\_\_\_\_ Subscriber ID or Rx BIN Number: \_\_\_\_\_

## 2. PRESCRIBER INFORMATION (MD, DO, PA, NP, APRN, Clinical PharmD, BCOP, BCACP)

Prescriber Name: \_\_\_\_\_ NPI \_\_\_\_\_ DEA \_\_\_\_\_ License: \_\_\_\_\_  
 Full Address: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Office Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email Address \_\_\_\_\_

MMI Script Hub is acting as an agent of the prescriber to conduct benefit investigation for & distribute medical supplies to the Insured and to discuss prescription information with prescriber, insurer and patient.

## 3. READ AND SIGN PATIENT AUTHORIZATION **REQUIRED**

By signing this authorization, I authorize my health plans, health care providers and pharmacy providers to disclose and I consent the release of my personal information, including my Protected Health Information ("PHI") as that term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, to Mueller Medical International ("MMI"), its representative and agents to assist patients in obtaining access to ProThelial for the prevention or treatment of mucositis. The information that I am authorizing to be disclosed may include personal, financial, medical and health insurance information about me, as well as information provided on this form and in any ProThelial prescription. This authorization will expire one (1) year from the date next to my signature in this section. I understand that any of my health care, pharmacy and medical supply providers may receive direct and/or indirect remuneration from MMI or its representatives and agents in connection with the uses of information described above.

I also understand that: 1. I do not have to sign this authorization and my health care providers and insurance company will not require me to sign this authorization to provide me with medical treatment or insurance benefits; 2. If I do not sign this authorization, I will not be eligible to receive assistance through MMI; 3. I have a right to receive a copy of this authorization; 4. I may be contacted by MMI as part of the assistance process, and may be asked to complete a clinical outcomes or patient satisfaction survey; and 5. I may cancel or revoke this authorization at any time by calling Mueller Medical at 860-477-0961, or by mailing a letter requesting a cancellation to Mueller Medical International, 1768 Storrs Road, Storrs, CT, 06268. Revocation of this authorization will end future uses and disclosures of my PHI by MMI, except to the intent those uses or disclosures were made in reliance upon this authorization.

**PATIENT SIGNATURE REQUIRED:**

**RESPONSIBLE PARTY, IF APPLICABLE:**

Print Name of Patient	Signature of Patient	Date	Print Name of Responsible Party	Signature of Responsible Party	Date
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## 4. PHYSICIAN ASSIGNED PRESCRIPTION PROGRAM (Please Check All that Applies)

**A**  Prescription **Does patient have:**  Active oral mucositis  Active esophageal mucositis  Active small bowel mucositis  Active large bowel mucositis

**B** **IF A REPEAT PRESCRIPTION THEN CHECK ALL THAT APPLY:**  Oral esophageal cancer prevented so far week \_\_\_ into treatment.

<input type="checkbox"/> Patient had no adverse reaction.	<input type="checkbox"/> Patient had adverse reaction. List: _____
<input type="checkbox"/> Oral soreness resolved.	<input type="checkbox"/> Never had this problem.
<input type="checkbox"/> Oral wound/ulcer/redness resolved.	<input type="checkbox"/> Never had this problem.
<input type="checkbox"/> Ease of swallowing restored.	<input type="checkbox"/> Never had this problem.
<input type="checkbox"/> Nausea, cramping, bloating resolved.	<input type="checkbox"/> Never had this problem.
<input type="checkbox"/> Chemo-induced diarrhea resolved.	<input type="checkbox"/> Never had this problem.
<input type="checkbox"/> Radiation-induced diarrhea resolved.	<input type="checkbox"/> Never had this problem.

## 5. PRESCRIPTION INFORMATION AND SIGNATURE

PROTHELIAL(TM) P-PAK500 10% Polymerized Sucralfate Malate Paste

**Directions:** 2.5-10ml Apply by Swab to Mouth/Tongue Lip Surfaces  
 Every 8 hours for 1 day then every 12 hours thereafter  
 Swish in mouth 5 Seconds, Hold in mouth 10 Seconds  
 Then  Expectorate OR  Swallow

**Check all that applies:** **A**  P-PAK 500 unit (4jars)  New Prescription  
 Lasts 3 -6 Weeks Depending of Use

**B**  P-PAK 500 unit (4jars)  Refill # \_\_\_\_\_

## **C** PRESCRIBER SIGNATURE (Required by law):

(no stamps) Dispense as written  
 (no stamps) Substitution allowed NY prescribers. Submit prescription on an original NY State Prescription blank. All other states, if not faxed, submit on a state-specific blank, if applicable for your state. This prescription form is valid only if received by fax.

## 6. DIAGNOSIS INFORMATION (Please Check All that Applies)

ICD-10 K12.31 Oral mucositis due to Antineoplastic Therapy  CANCER TYPE \_\_\_\_\_  
 ICD-10 K12.33 Oral mucositis due to Radiation Therapy ICD-10: \_\_\_\_\_ ICD-10: \_\_\_\_\_  
 OTHER Diagnosis \_\_\_\_\_  
 ICD-10: \_\_\_\_\_ ICD-10: \_\_\_\_\_

## 7. SPECIALTY PHARMACY / MEDICAL SUPPLIER

PROTHELIAL™ 10% Polymerized Sucralfate Malate Paste:

**First Unit Shipped to Prescriber to Instruct Patient in Proper Use**

Ship Refills to:  Patient  Prescriber

**FAX FORM TO: 860-477-0962**

Any Questions: Call 860-477-0961