PROTHELIAL™
POLYMERIZED SUCRALFATE MALATE PASTE
Definitive Management of Oral Mucositis

Mueller Medical International LLC
Turning Science Into Solutions

ProThelial Prescription Referral & Refill Form

(HIPAA Compliant)

Patient & Prescriber to Sign Form, Fax to 1-860-477-0962
OR a scanned copy by encrypted Email to mmi.sh.medsupl@muellermedical.com

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:_____ **SUBMIT PHOTOCOPY OF FRONT & BACK OF ALL INSURANCE CARDS**

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 me in obtaining access to ProThelial for the prevention or treatment of toxic mucositis, an emergency medical condition. 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. **I assign coverage benefit** for **ProThelial** to provider of ProThelial. **I specifically appoint** the Medical Director of the provider of ProThelial antidote as **an Authorized Representative** for all ProThelial insurance appeals or external review processes, including State and Federal regulators of my insurance plan. **This authorization will expire** either one (1) year from the date next to my signature in this section OR when all insurance appeals and/or external (independent) medical reviews for coverage of ProThelial are completed. **I understand that** my information, including my PHI, will be disclosed to MMI and used for the following: 1. To determine my eligibility for ProThelial coverage; 2. To obtain any required ProThelial coverage authorizations; 3. To communicate with my health care providers, including pharmacy and medical supply providers, and me about my medical care; and 4. To facilitate the provision of ProThelial by pharmacies or medical suppliers. This information may be further disclosed by MMI as necessary to facilitate ProThelial coverage and as such State and Federal privacy laws may no longer protect this information. **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

4. PHYSICIAN ASSIGNED PRESCRIPTION PROGRAM (Please Check All that Applies)

A **Patient has:** ☐ **Oropharyngeal Mucositis** ☐ **Esophageal Mucositis** ☐ **Small Bowel Mucositis (with Campiness/Nausea/Vomiting)** ☐ **Colonic Mucositis (with DIARRHEA)**

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

☐ Patient had no adverse reaction. Patient had adverse reaction. List: _____

☐ Oral soreness resolved.	☐ Never had this problem.	☐ Nausea, cramping, bloating resolved.	☐ Never had this problem.
☐ Oral wound/ulcer/redness resolved.	☐ Never had this problem.	☐ Chemo-induced diarrhea resolved.	☐ Never had this problem.
☐ Ease of swallowing restored.	☐ Never had this problem.	☐ Radiation-induced diarrhea resolved.	☐ Never had this problem.

5. PRESCRIPTION INFORMATION AND SIGNATURE

PROTHELIAL - P-PAK500 10% Polymerized Cross-linked 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 Gargle & Swish in mouth 5 Seconds, Hold in mouth 10 Seconds Then ☐ Expectorate OR ☐ Swallow; Is Safe to Swallow

Check all that applies: **A** ☐ P-PAK 500 unit (4jars) ☐ New Prescription w /1 Refill
Lasts 3 - 4 Weeks Depending of Use

B ☐ Refill #____ ☐ 1 ☐ 2 ☐ 3

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 & THERAPY INFORMATION (Please Check ALL that Applies)

☐ ICD-10 K12.31 ☐Oral ☐ GI mucositis due to
Chemotherapy Name_____
ImmunoTherapy Name_____

☐ ICD-10 K12.33 ☐Oral ☐GI mucositis due to
☐ **Standard Radiation Therapy**
☐ **IMRT Therapy**
☐ 28 days ☐ 42 days ☐ 49 days ☐____days

☐ CANCER TYPE_____
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 OR EMAIL US
at 860-477-0961, mmi.sh.medsupl@muellermedical.com