PROTHELIAL™
POLYMERIZED SUCRALFATE MALATE PASTE

Please complete form, sign, and fax all pages to 1-888-454-8488

ProThelial™ (Polymerized Sucralfate Malate Paste) **P-Pak500 500mL**	For assistance with any questions, call Mueller Medical 860-230-0766 Monday through Friday from 9 am to 5 pm Eastern Time

PATIENT INFORMATION

Patient name		Primary phone no.	
Street Address	City	State	Zip
SSN	DOB	Secondary phone no.	
Patient gender □ Male □ Female	Employer Name	Employer phone no.	

PRIMARY INSURANCE □ Uninsured

Plan name		
Phone no.		
Group policy no.		
Subscriber ID or Rx BIN no.		
Policyholder name/relationship to patient		

PRESCRIPTION INSURANCE (PBM)

Plan name	
Phone no.	
Group policy no.	
Rx BIN no.	Member ID no.
Relationship to patient	

PRESCRIBER INFORMATION

Prescriber name	**NPI**	**DEA**	**License**
Street address	**City**	**State**	**Zip**
Office contact name	**Office phone no.**	**Office fax no.**	

PRESCRIPTION □ **Diagnosis ICD-10: [ ] K12.31** Oral mucositis due to Antineoplastic Therapy
[ ] K12.33 Oral mucositis due to Radiation Therapy

□ PROTHELIAL™ P-PAK500 10% Polymerized Sucralfate Malate Paste □ Directions: 2.5 – 5ml every 8 hours for 1 day then every 12 hours Swish in mouth 30 sec then expectorate □ Directions (if different from above): _____ _____ _____ Quantity: _____(4jars/P-Pak500 Unit) Refills:_____ □ New Prescription □ Refill	**Physician's 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	**Allergies:** **Quantity:**

SPECIALTY PHARMACY

PROTHELIAL™ (10% Polymerized Sucralfate Malate Paste) is available exclusively through Accredo Specialty Pharmacy	
Ship to [ ] patient Ship to [ ] Prescriber	Office contact name:
Today's date:	Anticipated start date:

PROTHELIAL™
POLYMERIZED SUCRALFATE MALATE PASTE

Please complete form, sign, and fax both pages to 1-888-454-8488

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

I verify that the information provided herein is true and correct. I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Enrollment Form, such as my name, address, insurance, and medical information, is "protected health information."

By signing below, I agree to allow the entities described below to leave messages for me on the telephone number(s) that I provide.

I understand that my healthcare providers will not base any medical treatment decisions on my agreement to sign this Patient Authorization and Release. I understand that once information about me is released based on this authorization, federal privacy laws may not prevent the entities described below from further disclosing my information. However, I understand that such entities have agreed to only use or disclose information received for the purposes described in this authorization or as required by law. I understand that this authorization will remain in effect for ten (10) years after the date I sign this authorization. I understand that I have the right to revoke this authorization at any time by calling Mueller Medical (1-860-230-0766) or mailing a signed written statement of my revocation to 1640 Century Center Parkway, Memphis TN 38134, but that such a revocation would end my eligibility to participate in the programs as described. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on this authorization. This means that, after you revoke this authorization, your information may be disclosed among Mueller Medical International LLC. (Mueller Medical) and the company or companies that help Mueller Medical administer the programs in order to maintain records of your participation, but it will not otherwise be disclosed or used. I understand that my specialty pharmacy may receive payment in connection with the use and disclosure of my information for purposes allowed under this authorization.

Enrollment in MuellerMedicalCanHelp™ for reimbursement support and patient assistance: The patient, or patient's authorized representative, MUST sign this form in order to receive reimbursement support and assistance from MuellerMedicalCanHelp™ , If an authorized representative signs for the patient, please indicate your relationship to the patient. By signing below, you agree and understand that Actelion does not promise to find ways to pay for your medications, and that you know that you are responsible for the costs of your care. Before signing, you, the patient, should review, understand, and agree to the terms of this authorization and release.

1. Request and receive from your doctor, healthcare provider, health insurer, or pharmacist information necessary to investigate and resolve your insurance coverage, coding, and reimbursement inquiry, or review your eligibility for patient assistance programs and copay assistance;

2. Collect, use, and disclose to each other any information that you provide to MuellerMedicalCanHelp™ for the purpose of investigating and resolving your insurance coverage, coding, or reimbursement inquiry;

3. Disclose to your treating physician, healthcare provider, or pharmacist information you provided to MuellerMedicalCanHelp™ necessary to resolve your insurance coverage, coding, or reimbursement inquiry. By signing below, you also authorize your doctor, healthcare provider, and pharmacist to release information about your prescribed medications and medical condition requested by Mueller Medical and MuellerMedicalCanHelp™;

4. Contact your insurer, other potential funding sources, social workers, patient advocacy organizations, and/or patient assistance programs on your behalf in order to determine if you are eligible for health insurance coverage or other funds, and disclose to them information about your prescribed medications and medical condition that has been provided by you or your physician, healthcare provider, or pharmacist; and

5. Provide you with education and support available through Mueller Medical financial assistance programs; and

6. Disclose any information obtained from the sources listed above to specific individuals you have identified and allowed to receive information on your behalf and to third parties if required by law.

Patient name (print):	**Patient/authorized rep signature** (include relationship):	**Date:**

COMPLIMENTARY PATIENT SUPPORT SERVICES

By signing below, to amend the above authorization and release, you agree to the additional MuellerMedicalCanHelp™ patient support services, which are designed to provide you with product information and support that may include, but are not limited to:

1. Contacting you via telephone (including voice mail), mail, and email with information about these services, including providing information about PROTHELIAL™ and staying on your prescribed treatment regimen, and information about other support services and treatment offerings provided by Mueller Medical ;

2. Collecting, using, and disclosing any information that you have provided to MuellerMedicalCanHelp™ or any of the companies administering MuellerMedicalCanHelp™ for the purpose of providing you with information, contacting you, and otherwise administering such program;

3. Contacting and disclosing information about you to, and receiving information about you from, your treating physician, healthcare professional, or pharmacist for purposes of administering this patient support program. By signing below, you also authorize your doctor, healthcare provider, and pharmacist to release information about your prescribed medications and medical condition if requested by Mueller Medical or companies working with them for the purpose of administering the patient support program;

4. Providing you with adherence and nurse support programs that will complement your PROTHELIAL™ therapy;

5. Disclosing any information obtained from the sources listed above to third parties if required by law; and

6. Using such information to review, analyze, improve, and measure the effectiveness of the MuellerMedicalCanHelp™ program.

By signing below, I understand and agree to the terms of this authorization and release. If you are an authorized representative for the patient, please describe your relationship to the patient.

Patient name (print):	**Patient/authorized rep signature (include relationship):**	**Date:**