MuGard™ Oral Mucoadhesive

PATIENT REIMBURSEMENT & SUPPORT CENTER

PRESCRIPTION FORM

amag ASSIST

Phone: 844-635-AMAG
Fax: 877.591.2505

1 — STEP ONE: COMPLETE PATIENT AND INSURANCE INFORMATION

First Name	Last Name	Middle Initial	Allergies
DOB	SSN	❑ Male ❑ Female	
Street	City	State	Zip
Home Phone	Work Phone	Cell	Email
Primary Insurance	Policyholder	Relationship to Cardholder	
Policy #	Group #	Phone	
Secondary Insurance	Policyholder	Relationship to Cardholder	
Policy #	Group #	Phone	
Pharmacy Benefit Manager (PBM)	ID#	Group #	Phone

PATIENT FINANCIAL INFORMATION (Only required for Patient Assistance Program application)
Annual Household Income: $_____ Number Living in Household: _____ I understand that my eligibility for this program is subject to my meeting its income requirements. **By providing my income and household figures above, I certify that the income information I have provided is correct, and I agree that AMAG or its representatives have the right to seek additional information to verify this information.**

2 — STEP TWO: DIAGNOSIS AND MEDICAL INFORMATION

❑ ICD-10 K12.30 Oral mucositis (ulcerative) unspecified	Type of Cancer	ICD-10
❑ ICD-10 K12.31 Oral mucositis (ulcerative) due to antineoplastic therapy		
❑ ICD-10 K12.32 Oral mucositis (ulcerative) due to other drugs		
❑ ICD-10 K12.33 Oral mucositis (ulcerative) due to radiation	Other Diagnosis	ICD-10
❑ ICD-10 K12.39 Other oral mucositis (ulcerative)		
❑ ICD-10 K13.29 Other disturbances of oral epithelium, including tongue		

3 — STEP THREE: PRESCRIPTION INFORMATION AND SIGNATURE

REQUIRED: PLEASE FILL OUT THIS SECTION

Product	Dose	Directions	Quantity	Refills
MuGard®	5-10 ml	Swish and expel or swallow 4 – 6 times daily as prescribed for the management of Oral Mucositis	_____ Number of Bottles (8 oz)	

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by AMAG Pharmaceuticals, Inc and it's employees or agents to assist the patient in obtaining coverage for MuGard and/or to assist the patient in initiating or continuing MuGard therapy. I authorize Biologics, Inc. to convey this prescription to the dispensing pharmacy.

Prescriber Signature_____ NPI #_____ Date _____

4 — STEP FOUR: READ AND SIGN PATIENT AUTHORIZATION

By signing this authorization, I (the patient or the patient's personal representative) authorize my health plans, health care providers, and pharmacy providers to disclose, and I consent to the release of my personal information, including my Protected Health Information ("PHI") as that term is defined under the Health Insurance Portablility and Accountability Act of 1996 ("HIPAA"), to the AMAG Assist Patient Reimbursement and Support Center, a service provided by AMAG Pharmaceuticals, Inc. ("AMAG Assist"). The information that I am authorizing to be disclosed may include personal, financial, medical and health insurance information about me, as well as the information provided on this form and in any MuGard prescription. I understand that my information will be disclosed to the AMAG Assist and authorize the use of my information by AMAG Pharmaceuticals, Inc., its representatives and agents, for the following purposes (1) to determine my eligibility for MuGard coverage; (2) to obtain any required MuGard coverage authorization, (3) to communicate with my health care providers, including pharmacy providers, and me about my medical care, (4) qualification of benefits through the MuGard Patient Assistance Program, and; (5) to facilitate the provision of MuGard by pharmacies.

I understand that once my PHI has been disclosed to the AMAG Assist, federal privacy laws may no longer protect the information and it could be re-disclosed to others. 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 in order 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 the AMAG Assist; (3) I have a right to receive a copy of this authorization; (4) I will be contacted by the AMAG Assist as part of the assistance process; and (5) I may cancel or revoke this authorization at any time by calling the AMAG Assist's toll-free number 844-635-AMAG, or by mailing a letter requesting such cancellation to The AMAG Assist 11800 Weston Parkway, Cary, NC 27513; but that this cancellation will not apply to any information already used or disclosed; and (6) I may call the AMAG Assist at any time. This authorization expires one (1) year from the date signed below. Biologics may receive direct or indirect remuneration in connection with the use or disclosure of my protected health information for marketing purposes such as educational material about MuGard and programs that support patients with Oral Mucositis.

REQUIRED:

Print Name of Patient | Signature of Patient | Date

RESPONSIBLE PARTY, IF APPLICABLE:

Print Name of Patient | Signature of Patient | Date

5 — STEP FIVE: PRESCRIBER INFORMATION

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

Ordering Prescriber	First Name	Last Name		❑ Physician	❑ PA
Institution				❑ Advanced Practice Nurse	
Prescriber Address	Suite	City	State	ZIP	
Office Contact		Phone	Fax		
Specialty		License #			
Physician (if different than prescriber)	First Name	Last Name		NPI#	
AMAG ID		Territory ID			