Soleva ASSIST

PRESCRIPTION FORM

MuGard™ Oral Mucoadhesive

Soleva Pharma

Phone: 866-900-5634
Fax: 888-307-0071
Alternate Fax: 929-977-0466

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

2 — STEP TWO: DIAGNOSIS AND MEDICAL INFORMATION

- ☐ ICD-10 K12.30 Oral mucositis (ulcerative) unspecified
- ☐ 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
- ☐ ICD-10 K12.39 Other oral mucositis (ulcerative)
- ☐ ICD-10 K13.29 Other disturbances of oral epithelium, including tongue

Type of Cancer	ICD-10

Therapies Tried and Failed with Dates

3 — STEP THREE: 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 use and disclose 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"). I authorize my personal information to be disclosed to Soleva Pharma , LLC., its representatives and agents, including the Soleva Assist Center. ("Soleva 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 authorize that my information may be used for the following purposes (1) to determine my eligibility for MuGard coverage; (2) to obtain any required MuGard coverage authorization, (3) to communicate with Soleva Assist, my health care providers, including pharmacy providers, and me about my medical care, (4) qualification of benefits through Soleva Assist, and; (5) to facilitate the provision of MuGard by pharmacies. I understand that my health care providers, including pharmacy providers, may receive payment from Soleva Pharma, LLC for the use or disclosure of my information, I understand that once my PHI has been disclosed to Soleva Pharma, LLC, 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 Soleva Assist; (3) I have a right to receive a copy of this authorization; and (4) I may cancel or revoke this authorization at any time by calling Soleva Assist's toll-free number 866-900-5634 or by mailing a letter requesting such cancellation to Soleva Assist, 2417 3rd Ave, Ste 406, Bronx, NY 10451; but that this cancellation will not apply to any information already used or disclosed. This authorization expires one (1) year from the date signed below.

REQUIRED: **RESPONSIBLE PARTY, IF APPLICABLE:**

Print Name of Patient | Signature of Patient | Date | Print Name of Responsible Party | Signature of Responsible Party | Date

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. I certify that the income information I have provided is correct, and I agree that Soleva or its representatives have the right to seek additional information to verify this information.

4 — STEP FOUR: 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	____ 6 bottles (8 oz)	

Prescriber Signature _____ NPI # _____ Date _____

5 — STEP FIVE: PRESCRIBER INFORMATION

Deliver to: ☐ Patient's Home ☐ Physician's Office Needs by:

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#	
		Territory ID			

For Representative Use. Not Mandatory