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.
☐ Oral wound/ulcer/redness resolved. ☐ Never had this problem.
☐ Ease of swallowing restored. ☐ Never had this problem.

☐ Nausea, cramping, bloating resolved. ☐ Never had this problem.
☐ Chemo-induced diarrhea resolved. ☐ 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

Authorization Representation to Contact & Bill Your Insurance for ProThelial®

Signing this form **will not** increase patient's (your) financial responsibility; however, without your (the patient's) signature your (the patient's) insurance may not pay MMI Script Hub & Medical Supplies LLC for the emergency anti-dote services prescribed by your doctor and provided to you. This may leave the full billed charges as your (the patient's) financial responsibility.

Patient Name: ___________________________________ Date(s) of Service: ___________________

Policyholder/Insured Name: _______________________ Phone No: __________________________

Assignment of Insurance Benefits; Financial Responsibility: MMI Script Hub & Medical Supplies LLC will work for and with you to obtain proper reimbursement from your insurance plan. An assignment of benefits will assist MMI Script Hub & Medical Supplies LLC in working with your insurance plan.

I assign all applicable ProThelial health insurance benefits to which I and/or my dependents are entitled to MMI Script Hub & Medical Supplies LLC. I certify that the health insurance information I have provided is accurate as of the date set forth below and that I am responsible for keeping it updated. I will use my best efforts to assist with submitting insurance claims.

I authorize MMI Script Hub & Medical Supplies LLC to submit claims, on my and/or my dependent's behalf, for payment to Medicare, Medicaid, or any other payer for services provided to me or my dependent. I also instruct my benefit plan (or its administrator) to pay MMI Script Hub & Medical Supplies LLC directly for the services rendered to me or my dependent. To the extent that my current policy prohibits direct payment to MMI Script Hub & Medical Supplies LLC, I instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and MMI Script Hub & Medical Supplies LLC upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check to me and mail it directly to MMI Script Hub & Medical Supplies LLC.

I assign the right to appeal payment denial or other adverse decisions made by my benefit plan (or its administrator), as well as the right to file a complaint or grievance, bring suit, or pursue arbitration, to MMI Script Hub & Medical Supplies LLC on my behalf. I understand that my medical condition is an emergency toxicity reaction to therapy authorized by my insurer who is obligated to cover ProThelial antidote services as prescribed by my physician. I agree to immediately remit to MMI Script Hub & Medical Supplies LLC any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to MMI Script Hub & Medical Supplies LLC.

Authorization to Release Information: MMI Script Hub & Medical Supplies LLC may need to obtain information from other sources in order to receive appropriate reimbursement from all available insurance sources.

I authorize and direct any holder of medical information or documentation to include city, county and state accident reports about me or my dependent to release such information to MMI Script Hub & Medical Supplies LLC, its billing agents, CMS, its carriers and agents and/or any other payers or insurers as may be appropriate to determine any benefits payable for these or any other medical services provided to me or my dependent by MMI Script Hub & Medical Supplies LLC.

ERISA Authorization (Only Applies to Employer Sponsored Plans): ERISA is a federal law that allows a patient's Authorized Representative to handle the patient's insurance claim.

I hereby designate MMI Script Hub & Medical Supplies LLC as my Authorized Representative under ERISA and its regulations. I hereby designate, authorize, and convey to MMI Script Hub & Medical Supplies LLC to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause of action that I may have relating to such insurance policy and/or benefit plan; and (2) the right and ability to pursue any claim, right, or cause of action in connection with said insurance policy and/or benefit plan, including but not limited to any cause of action under ERISA, with respect to any healthcare expense incurred as a result of the services I or my dependent received from MMI Script Hub & Medical Supplies LLC and, to the extent permissible under the law, to claim, such benefits, claims, or reimbursement, and any other applicable remedy, including expenses, damages, penalties or fines. To the extent that the applicable insurance policy and/or employee health care benefit plan lawfully prohibits such any of the assignments described above in this paragraph, I authorize MMI Script Hub & Medical Supplies LLC to take the actions described in this paragraph on my behalf.

Patient Signature: ______________________________________ Date: ______________________

Representative Signature: ___________________________________ Date: ______________________

Representative Name: ______________________________________

Medical Director for MMI Script Hub & Medical Supplies LLC

(A representative is someone other than the patient who is responsible to the insurer for the patient's medical and/or financial health affairs for a specific therapy or medical service)

A copy of this form is valid as an original.