How to Prescribe the Chemo Mouthpiece® oral cooling device through Zeal Specialty Pharmacy

How to Prescribe:

1. Complete the attached Referral Form and ensure the healthcare provider and the patient sign it.

2. Patient Assistance Program: Patients who would like to be eligible **must** also fill in and sign the Household Income statement.

3. Submit Referral Form to Zeal Specialty Pharmacy by **Fax:** 877-329-9325.

4. Zeal Coordinates benefits investigation, prior authorization support, patient onboarding and **Patient Assistance Program (PAP).**

5. Direct-to-Patient Fulfillment: The Chemo Mouthpiece Patient Kit is shipped directly to the patient with support resources and instructions.

Questions? Contact Zeal Specialty Pharmacy

Phone: 888-412-ZEAL (9325)
Fax: 877-FAX-ZEAL (329-9325)
eRx NPI: 1093424905

100 Business Center Drive
Suite 300
Pittsburgh, PA 15205

Indication for Use: The Chemo Mouthpiece® is intended to cool the oral mucosa to reduce the incidence and severity of chemotherapy induced oral mucositis in adult patients. Rx only. See full prescribing information and Important Safety Information at chemomouthpiece.com

Start prescribing today through Zeal Specialty Pharmacy

CHEMO MOUTHPIECE®

Chemo Mouthpiece® Referral Form

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Zeal Specialty Pharmacy

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

CMP26-01

PATIENT INFORMATION

First Name	Last Name	Date of Birth ____ /____ / ____	Gender ☐ Male ☐ Female
Address	City	State	Zip
email	Home Phone	Cell Phone	

PRESCRIBER INFORMATION

Prescriber Full Name		Prescriber Credential	
Practice Address	City	State	Zip
Office email	Office Phone	Office Fax	
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – *please include any relevant office visit/lab notes to support this prescription*

Type of Cancer: ICD-10 Code:		Other Diagnosis: ICD-10 Code:
ICD-10 Code	☐ K12.30 – Oral Mucositis (ulcerative), unspecified	☐ K12.33 – Oral Mucositis (ulcerative), due to radiation
	☐ K12.31 – Oral Mucositis (ulcerative), due to antineoplastic therapy	☐ K12.39 – Oral Mucositis (ulcerative)
	☐ K12.32 – Oral Mucositis (ulcerative), due to other drugs	☐ K13.29 – Other disturbances of oral epithelium, including tongue
Ship to: ☐ Patient ☐ Physician/Clinic		Date Shipment Needed By: ____ /____ / ____

PRESCRIPTION – *please check all boxes across row*

Medication	Directions	Quantity	Refills
☐ **Chemo Mouthpiece®**	Freeze all 6 units for at least 6 hours. Insert 1 unit into mouth every 30 minutes during infusion, replacing unit every 30 minutes. Continue use for an additional 10-15 minutes post infusion. Use at home 2 or more times per day for the next 5 days. Always clean and store devices in the freezer after each use.	1 – six pack patient kit	☐ 0 ☐ Other:_____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc.. Non-compliance with state-specific requirements could result in outreach to the prescriber.*

PATIENT AUTHORIZATION – PATIENT ASSISTANCE PROGRAM

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 Portability and Accountability Act of 1996 ("HIPAA"), to the CMP Assist Patient Reimbursement and Support Center, a service provided by Chemo Mouthpiece, LLC ("CMP Assist"). The information that I am authorizing to be disclosed may include but not limited to, personal, financial, medical and health insurance information about me, as well as the information provided on this form and in any Chemo Mouthpiece prescription. I understand that my information will be disclosed to the CMP Assist and authorize the use of my information by Chemo Mouthpiece, LLC, its representatives and agents, for the following purposes (1) qualification of benefits through the CMP Patient Assistance Program; (2) to determine my eligibility for Chemo Mouthpiece coverage with any Local and National Foundations; (3) to obtain any required Chemo Mouthpiece coverage authorization with my insurance payer; (4) to communicate with my health care providers and myself about my medical care; (5) to initiate the fulfillment of a Chemo Mouthpiece order through the various distribution channels.

I understand that after my PHI has been disclosed to the CMP Assist, federal privacy laws may no longer protect this info 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 may not be eligible to receive assistance through the CMP Assist; (3) I have a right to receive a copy of this authorization; (4) I will be contacted by the CMP Assist as part of the assistance process; and (5) I may cancel or revoke this authorization at any time by calling the CMP Assist's number 866-496-8858, or by mailing a letter requesting the cancellation to CMP Assist, 10 Railroad Avenue, Closter, NJ 07624; but that this cancellation will not apply to any information already used or disclosed; and (6) I may call the CMP Assist at any time. This authorization expires one (1) year from the date signed below. Chemo Mouthpiece, LLC may receive direct or indirect remuneration in connection with the use or disclosure of my protected health information only for marketing purposes such as educational material about Chemo Mouthpiece and programs that support patients with oral mucositis.

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 CMP or its representatives have the right to seek additional information to verify this information.**

Patient signature: _____ **Responsible Party:** _____ **Date:** ____ /____ / ____

IF APPLICABLE