

**Prescriber**

✓	Prescriber Name	Designation	NPI #

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Office Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ | Office Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_  
 ➔ Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_  
 Patient Address Verified?  Yes  No Emergency Contact Name: \_\_\_\_\_ Cell#: \_\_\_\_\_

**Insurance**

Primary Insurance \_\_\_\_\_ Policy Holder \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Insurance Co. Phone # \_\_\_\_\_  
 Check if Medicare or Medicaid  
 Check if No Insurance  
**Attach Copy of Insurance Card (Front and Back)**  
 Co-Pay Assistance: \$0 co-pay will be automatically applied for ALL eligible patients\*

**Patient Diagnosis**

Primary Diagnosis (Required) \_\_\_\_\_ ICD-10 \_\_\_\_\_ Allergies \_\_\_\_\_  
 Stage \_\_\_\_\_ Please attach patient medication profile/list \_\_\_\_\_

**Oravig Rx**

Check to Prescribe

**Oravig® - Dispense:** Oravig bottle (14-day supply). **Dose:** Apply 1 tablet daily. (Medicare pending)  
**Oral thrush/Oropharyngeal Candidiasis Diagnosis:** once-daily **ORAVIG®** (miconazole) buccal tablets 50 mg  

✓	Code	Description (check all that apply)
	ICD-10 B37.0	Candidal Stomatitis
	ICD-10 B37.9	Candidiasis, unspecified


**Refills (Select One):**  01  02  03  04

**Gelclair Rx**

Check to Prescribe

**Gelclair® - Dispense:** Gelclair 90 packets (30-day supply). **Dose:** Rinse with 1 packet 3x per day.  
**Oral Mucositis Diagnosis:**

✓	Code	Description (check all that apply)
	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)

  
**Refills (Select One):**  01  02  03  04

**Zuplenz Rx**


4 mg

8 mg

Check to Prescribe

**Zuplenz® - Dispense:** Zuplenz \_\_\_\_\_ boxes of 30 oral soluble film strips (multi-day supply). **Dose:** Place on tongue as directed.  
**Check one:**  HEC/Adult  MEC/Adult  MEC/Ped  RINV  PONV (Medicare pending)  
**CINV, RINV, or PONV Diagnosis:**

✓	Code	Description (check all that apply)
	ICD-10 R11.0	Nausea
	ICD-10 R11.10	Vomiting, unspecified
	ICD-10 R11.11	Vomiting without nausea
	ICD-10 R11.12	Projectile vomiting
	ICD-10 R11.2	Nausea with vomiting, unspecified

  
**Refills (Select One):**  01  02  03  04

# FORTOVIA

THERAPEUTICS

## Fortovia Direct Rx Form

*Prescription savings and free delivery to patient's home in 24 hours*

**Fax form to: 800-269-5493**

**OR**

**E-prescribe:** BioPlus Specialty Pharmacy Svcs  
in Altamonte Springs, FL 32701

**NPI# 1174517452 NABP# 1078535**

**Questions? Call 888-292-0744 Ext 1**



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