

Fill out all the fields below and fax the form to 253-539-6035 to apply for discounted Caphosol®

PRESCRIBER INFORMATION

Prescriber's Name	Office Phone	Fax	Contact	
Address	City		State	Zip

PRESCRIPTION INFORMATION

<p>Caphosol Standard Dosing:</p> <ul style="list-style-type: none"> • Treatment of Mucositis: 4 doses per day from onset of cancer treatment. Up to 10 doses per day if pain from mucositis is experienced: • Relief of dry mouth: 2-10 times per day or as instructed by physician <p>→ Diagnosis: <input type="checkbox"/> Mucositis (528.00) <input type="checkbox"/> Xerostomia (527.7)</p> <p>→ Directions: Use _____ doses per day. May use up to 10 doses per day if needed</p>
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PATIENT INFORMATION

Patient Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Medications Allergies	
Address	City	State	Zip	Contact Phone #	
Insurance Carrier ID	Group #	Carrier Phone Number		Cardholder Name	

CAPHOSOL® Coupon Program

I hereby represent, warrant, and certify that I am a beneficiary of Medicare Parts A and B, and that I do not have Medicare Advantage coverage or any coverage from any other third party payer, including any employer self-funded plan. I hereby further acknowledge that I have read, understand, and agree to the terms and conditions stated on the bottom of this form. I hereby request that EUSA, through its vendor Franciscan Pharmacy, issue me a coupon for a \$563.37 reduction in the cost of Caphosol® off of the month-pack WAC price of \$691.37, resulting in a greater than 80% cost savings.

Terms and Conditions

Coupon is valid for customers certifying no insurance coverage, other than Medicare fee-for-service, including no coverage under a Medicare Advantage Plan. The cash value of this coupon is \$0.01, and is void where prohibited by law, taxed, or restricted, including within the Commonwealth of Massachusetts. This coupon is valid on a purchase for a full course of CAPHOSOL® therapy and may not be used for any other product, or in conjunction with any other free trial, coupon, discount, prescription savings card, or any other offer. The coupon is non-transferable, and any attempt to transfer this coupon shall be void. Redemption is only through Franciscan Pharmacy. This program may be discontinued by EUSA Pharma at any time, without notice.

Physician Signature _____

Date _____

Patient Signature _____

Date _____