

# Gelclair® Medical Justification Form



<b>PATIENT</b>	PATIENT NAME	DATE OF SERVICE
	DOB	M <input type="checkbox"/> F <input type="checkbox"/> SOCIAL SECURITY #
	ADDRESS	PHONE (     )
	CITY, STATE, ZIP	
<b>INSURANCE</b>	INSURANCE NAME	<input type="checkbox"/> Will fax insurance info separately
	MEMBER ID #	GROUP #
	PHONE (     )	
	SUBSCRIBER NAME IF OTHER THAN PATIENT	RELATIONSHIP SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>
<b>PHYSICIAN</b>	PHYSICIAN NAME	PHONE
	ADDRESS	FAX
	CITY, STATE, ZIP	
	DEA #	UPIN #
<b>Gelclair® Prescription</b>	Gelclair® Bioadherent Oral Gel (15 mL sachets) NDC 24477-0010-15 Rinse TID or PRN 1 hour prior to meals <input type="checkbox"/> 6 boxes (1350 mL's) =1 month supply <input type="checkbox"/> _ boxes (225 mL's per box)	
	Documentation of failed alternatives:	
<b>Medical Justification</b>	Gelclair® is a prescription, concentrated viscous gel that adheres to the mucosa helping to relieve the pain of oral lesions, especially mucositis, secondary to chemotherapy and/or radiation. Since Gelclair® contains no alcohol and no local anesthetic, it is designed to be non-stinging and non-numbing while preserving the sensation of taste and restoring the ability to eat and drink.	
<b>Signature</b>	Physician's Name: (please print) _____	
	Physician's Signature: _____	

Diagnosis: <input type="checkbox"/> Oral Mucositis 528.00 <input type="checkbox"/> Other _____
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