



PRESCRIPTION FORM

Fax: 877-546-1779

Phone: 877-373-2734

Today's Date (mm/dd/yyyy): / /

1 PATIENT INFORMATION (MEDICATION WILL BE DELIVERED TO PATIENT'S HOME)			
Name (first, last)		Patient Gender	Female <input type="checkbox"/> Male <input type="checkbox"/>
Patient Home Address		City	State Zip
Patient Date of birth (mm/dd/yyyy): / /		Primary Phone #	Mobile/Alt. Phone #
Primary Language (check one): English <input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/>		Drug Allergies	ICD10 code
2 PRESCRIBER INFORMATION			
Prescriber Name		Practice Email	Practice Contact
Practice Name		Primary Phone #	Fax # Preferred method of communication Phone <input type="checkbox"/> Fax <input type="checkbox"/>
Prescriber NPI #	Practice Address	City	State Zip
3 PRESCRIPTION BENEFIT INSURANCE			
Prescription Insurance		Cardholder ID #	Insured Name
Group #	BIN #	Rx PCN #	Plan Phone #
4 PRIMARY MEDICAL INSURANCE			
Medical Insurance		Policy #	Group #
Insured Name		Plan Phone #	
5 PATIENT AUTHORIZATION & COPAY ASSISTANCE PROGRAM ELIGIBILITY ATTESTATION			
<p>PATIENT AUTHORIZATION: Patient should read this Patient Authorization and sign below. I authorize my healthcare providers and health plans to disclose my protected health information such as records and my medical treatment and medications ("PHI") to CareMetx, LLC to use and disclose my PHI to: (1) determine my eligibility for benefits through the NeutraSal Direct Access Program, including copay assistance; (2) communicate with my health care providers and me about my medical care; (3) provide support services including facilitating the provision of product to me, verifying reimbursement and assisting with insurance coverage; and (4) allow authorized representatives of Bausch Health US, LLC who are under a duty of confidentiality to audit and improve the NeutraSal Direct Access Program. I understand that my pharmacy, health insurers, or third-party vendors may receive payment from Bausch Health US, LLC for the services described above. I understand that once my PHI has been disclosed as described above, federal privacy laws may no longer restrict its further disclosure. CareMetx agrees to use and disclose my PHI only for the above purposes and as permitted by law. I also understand I may refuse to sign this authorization and that my health care providers and health plans may not condition my enrollment in or eligibility for health plan benefits or my treatment on whether I sign this authorization. I may cancel this authorization by notifying CareMetx in writing and faxing the cancellation 877-373-2734 or mailing it to CareMetx, LLC, 610 Crescent Executive Ct., Suite 200, Lake Mary, FL 32746. This cancellation will not apply to information that has already been disclosed under this authorization before receipt of the cancellation. I am entitled to a copy of this signed authorization, which expires 10 years from the date I sign it, unless state law mandates a shorter period.</p>			
Patient signature _____		Date (mm/dd/yyyy) _____	
<p>COPAY ASSISTANCE PROGRAM ELIGIBILITY TERMS AND CONDITIONS: Eligibility Restrictions and Requirements. See full Terms and Conditions on the back of this form.* The NeutraSal Direct Access Copay Assistance Program is available for US residents only. All prescriptions must be dispensed from a pharmacy qualified by the NeutraSal Direct Access Program. The copay assistance program is not valid for prescriptions eligible to be reimbursed, in whole or in part, by Medicare, Medicaid, Tricare, or any other federal- or state-funded healthcare benefit program, or by private plans or other health or pharmacy benefit programs which reimburse the patient for the entire cost of the prescription drugs. The maximum copay coverage is \$1,500. The NeutraSal Direct Access Program does not represent prescription drug coverage or insurance and is not intended to substitute for such coverage. Bausch Health reserves the right to rescind, revoke, terminate, or amend this offer at any time, without notice. This offer is not valid for any person that is 65 years of age or older without commercial insurance. You must be 18 years of age or older to redeem this offer for yourself or a minor.</p>			
By signing below, you are indicating that you meet the eligibility criteria and agree to the terms and conditions outlined above.			
PATIENT CONSENT FOR SHIPMENT: As the patient, I give consent for the dispensing pharmacy to ship the medication directly to my home or residence as directed by the prescriber. For questions call 877-373-2734.			
Patient signature _____		Patient date of birth (mm/dd/yyyy) _____	Prescriber name _____
6 PRESCRIPTION & PRESCRIBER CONSENT			
The dental practitioner prescribing NeutraSal [®] (supersaturated calcium phosphate rinse) will determine the appropriate course of therapy for the patient. Note: Based on 30-day supply. Number of rinses per day = Number of boxes being prescribed.			
Complete the following prescription prior to faxing. The quantity dispensed represents no greater than a 30-day supply. New York Prescribers may attach an official NY prescription.			
NeutraSal[®] (supersaturated calcium phosphate rinse)			
Rinses per day: <input type="checkbox"/> 2-4 <input type="checkbox"/> 4-8 <input type="checkbox"/> 8-10 <input type="checkbox"/> Other: _____ Refill: _____			
My signature indicates my (1) authorization for CareMetx, LLC ("Business Associate" or "BA"), as the operator of the NeutraSal Direct Access Program, to act on my behalf for the limited purposes of transmitting this prescription by any means allowed under applicable law to the appropriate pharmacy designated by the patient's benefit plan. This may include obtaining, use and disclosure of protected health information as defined in 45 CFR 160.103 ("PHI") about my patients, to and from (i) patient's insurer, including eligibility and other benefit information, for my payment and/or healthcare operation purposes and (ii) healthcare providers, such as specialty pharmacies ("SPs"), for treatment purposes, including to forward the prescription and associated PHI to a valid SP and to track the status of medications dispensed by SPs for my patients for coordination of care and related purposes and (2) certification that I have received all necessary permission from such patients and other parties to permit the disclosure and use of their patient's PHI as described in this paragraph. BA may use PHI if necessary, for the proper management and administration of BA or to carry out the legal responsibilities of BA. BA may de-identify, use, and disclose PHI of my patients to the extent allowed by 45 CFR 164.504, provided that the de-identification complies with the requirements of 45 CFR 164.514(b). BA shall maintain administrative, technical, and physical safeguards to ensure the availability, integrity and confidentiality of PHI and shall notify me of any impermissible use or disclosure Security Incident and Breach of Unsecured PHI as required by law. This agreement incorporates and BA agrees to comply with requirements of 45 CFR 164.504 and 164.314(a)(2). This BA agreement shall terminate upon any material violation of this agreement by BA, upon the written request of physician, or two years after the signature date below. Upon termination, BA shall destroy PHI in its possession.			
Prescriber signature (DO NOT STAMP) _____		Date (mm/dd/yyyy) _____	

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NeutraSal® COPAY ASSISTANCE PROGRAM TERMS AND CONDITIONS

*Offer Restrictions and Eligibility Requirements

- This offer is only valid for patients with private commercial insurance, where NeutraSal® (supersaturated calcium phosphate rinse) is a covered medication.
- This offer is not valid for any person eligible for reimbursement of prescriptions, in whole or in part, by any federal, state, or other governmental programs, including, but not limited to, Medicare (including Medicare Advantage and Part A, B, and D plans), Medicaid, TRICARE, Veterans Administration or Department of Defense health coverage, CHAMPUS, the Puerto Rico Government Health Insurance Plan or any other federal or state health care programs.
- You agree not to seek reimbursement for all or any part of the benefit received through this offer and are responsible for making any required reports of your use of this offer to any insurer or other third party who pays any part of the prescription filled.
- Offer good only in the United States through the NeutraSal Direct Access Program. This offer is not valid where otherwise prohibited by law, taxed, or otherwise restricted.
- This offer is not valid with other offers. The coupon has no cash value. No cash back.
- This benefit can be used only for a NeutraSal prescription filled by Transition Patient Services (TPS) or Vital Care specialty pharmacy and dispensed to the patient as authorized below.
- You must be 18 years of age or older to redeem this offer for yourself or a minor. This offer cannot be redeemed at government-subsidized clinics.
- This offer is only valid on one initial prescription fill of NeutraSal and up to ten prescription refills.
- The maximum benefit available is \$1,500 per prescription fill. You are responsible for all additional costs and expenses after the maximum benefit is reached.
- If you receive coverage through a health savings account (HSA) or similar arrangement, it is your responsibility to know how claims are processed and understand that amounts paid by the third party for your NeutraSal prescription may be deducted from your benefits limit automatically.
- This offer is not health insurance. This offer expires on December 31, 2021.
- Bausch Health US, LLC reserves the right to rescind, revoke, terminate, or amend this offer at any time, without notice.

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