



Faxed prescriptions can only be accepted from a prescribing practitioner. e-prescribe to: Onco360 Oncology Pharmacy Louisville, KY **NPI# 1437577988** 

Pharmacy 877.662.6633 Fax 877.662.6355

## **GELX® Oral Gel Order Form**

Patient Information (REQUIRED)			Date:	
Patient Name:	Date of Birth:	Sex: □M □F Las	t 4 Digits of SSN:	
Address:	City:		State:	Zip:
Home Ph: Cell Ph:	Email:			
Patient Weight: lbs. Patient Hei	ght: Allergies:			
Pharmacy Benefit Manager (REQUIRED) Please provide copies of both sides of the patient's card(s)				
PBM Name:			PCN#:	
Rx Group#:	Memb_	er ID#:		
Medical/Health Insurance Info. (REQUIRED) Please			Delian II	Di
Primary:				
Address:				
Secondary:				
Address:	City:		State:	Zip:
Diagnosis Code		Descripti	on	
☐ 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			
g □ ICD-10-K12.33	Oral mucositis (ulcerative), due to radiation			
□ ICD-10-K12.39	Oral mucositis (ulcerative)			
□ ICD-10				
	1			
Medication Check to Prescribe	SIG: Directions	_	Quantity	Refills   1 Refill
	☐ Rinse with 1 packet 3x per d	ау. Ц	GELX 90 packets (30-day supply)	☐ 2 Refills
CRIPTION	□ Other:	_		☐ 3 Refills
g goly "			Other	☐ 4 Refills
<b>SCIN</b>				
ORAL GEL				
Physician Information				
Prescriber name:	Contact:			
SH Email:		City: Fax: NPI #:		
<b>E</b>				
Tax ID # (needed for funding):	Prescriber Signature (required by	/ Iaw):		Date:
Chinning Instructions				
Shipping Instructions Ship to:				

State law for MO/NY/OH/VA/VT allows only 1 medication per order form. Please use a new form for additional medications.

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