# Fax this Rx to: 303-480-9115 Or email to: Order@CranioRehab.com 40125

| | |
|---|---|
| **Prescriber:** | NPI: |
| Phone: | Fax: |
| Address: | Email: |
| | Office Contact: |

| | |
|---|---|
| **Other Requesting Provider:** | ☐ SLP ☐ Other: |
| Phone: | |
| Email: | ☐ Request Rx from prescriber, if not below/attached. |

| | | | |
|---|---|---|---|
| **Patient:** | | **Phone:** | |
| *Address: | | *DOB: | |
| City, State Zip: | | Cell/Work Ph: | |
| Known Allergies: | | | |

**Insurance**

Insurance: _____

ID or Policy #: _____

RX Group #: _____

RX BIN #: _____

RX PCN: _____

**Prescription**

## SalivaMAX®

Super Saturated Calcium Phosphate Rinse

| | | | |
|---|---|---|---|
| **Daily Rinses** | 8-10 | 4-8 | 2-4 |
| **Quantity:** | ☐ **300** | ☐ **240** | ☐ **120** |

**Refill:** ☐ **PRN** ☐ **4** ☐ **2**

## Orapeutic®

Oral Hydrogel Wound Dressing

| 2-Week Rx | **Generalized Legion** (Mucositis any grade) Application = 3ml | **Localized Legion** (Ulcer, incision, trauma) Application = 1ml |
|---|---|---|
| **Application** | 4-6x/day | 6-8x/day |
| **Quantity:** | ☐ **25** syringes | ☐ **10** syringes |

**Refill:** ☐ **PRN** ☐ **4** ☐ **2**

**Prescriber Signature:** **Date:**

☐ **Your prescription has been sent to the pharmacy.**

**To fill this prescription, this form must be faxed or sent to the pharmacy.**
You should receive your prescription or more information within 3-5 days.

**Contact the pharmacy directly for prescription and order questions at 866-694-2553.**
Don't forget to ask the pharmacy about the co-pay assistance program sponsored by Forward Science. Rx Not covered: Inquire about the direct cash price.