Fountain Valley Medical Center Pharmacy Oral Mucositis Order Form

Fax completed form via fax at 714-979-0532 or email at fountainvalleyrx@outlook.com

Patient Information	Prescriber Information
Patient Name:_____DOB:_____	Prescriber:_____
Street Address: _____	NPI#:_____ DEA#:_____
City/State/Zip:_____	Street Address: _____
Phone:_____ Email:_____	City/State/Zip: _____
Allergies: _____	Phone:_____ FAX:_____
Insurance ID:_____	
BIN:_____ CARRIER: _____	
GROUP:_____ PCN:_____	

MEDICATION ORDER

Oral Mucositis

☐ Gelclair Oral Gel (oral mucosal barrier) **QTY: 90 packets (1350 mL) Refills: _____**

Sig: Rinse, gargle and spit contents of 1 packet (15ml) mixed in water three times daily as needed. Avoid eating or drinking for at least 30 minutes after use.

☐ Lidocaine 2%, viscous solution (topical oral anesthetic) **QTY: 100ml x _____ Refills: _____**

Sig: Rinse, gargle and spit 15 ml every 4 to 6 hours as needed for oral pain.

Prescriber's Signature:_____

Date:_____

Download Fillable forms on our website at www.fvmcp.com in the Forms section

•FOUNTAIN VALLEY MEDICAL CENTER PHARMACY•
11100 WARNER AVE., FOUNTAIN VALLEY, CA 92708
(714) 979-9600 • FAX (714) 979-0532