SalivaMAX™
www.SalivaMAX.com

Fax Prescription to:
(866) 694-2555

PATIENT INFORMATION

Patient Name: SSN (last 4):

Date of Birth: ☐ Male ☐ Female

Cell Number: Home Number:

Address:

City, State, Zip:

Known Allergies:

Member ID Number: RX Group Number:

RX BIN Number: RX PCN:

SalivaMAX™
Supersaturated Calcium Phosphate Rinse

Rinse: ☐ 8 -10 ☐ 4 - 8 ☐ 2 - 4 times daily

Quantity: ☐ 300 ☐ 240 ☐ 120

Refill: ☐ PRN ☐ 4 ☐ 2

PRESCRIBER SIGNATURE: ______________________ **DATE:** ____________

PRESCRIBER INFORMATION

Name:

NPI: DEA:

Address:

City, State, Zip:

Phone Number:

Fax Number: