Santyl®

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

Patient Information

Patient Name:	Date of Birth:	☐ Male ☐ Female	
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Social Security Number:	E-Mail:		
Allergies:		☐ NKDA	
☐ Pick Up / Ship to: ☐ Patient ☐ Office ☐ Alternative Address:			

Insurance: Please fax copy of insurance card (front and back)

Prescriber Information

Practice Name:			
Office Contact:			
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information

Diagnosis code:	Is this a burn patient? ☐ Yes ☐ No

Comments/Notes:

Wound Care Plan	Wound Location	Prescriber
☐ Wound 1 _____ cm x _____ cm		☐ _____ NPI: _____
☐ Wound 2 _____ cm x _____ cm		☐ _____ NPI: _____
☐ Wound 3 _____ cm x _____ cm		☐ _____ NPI: _____
☐ Wound 4 _____ cm x _____ cm		☐ _____ NPI: _____
☐ Wound 5 _____ cm x _____ cm		☐ _____ NPI: _____
☐ Wound 6 _____ cm x _____ cm		☐ _____ NPI: _____
☐ Wound 7 _____ cm x _____ cm		☐ _____ NPI: _____
☐ Wound 8 _____ cm x _____ cm		☐ _____ NPI: _____
☐ Other:		☐ _____ NPI: _____

Prescription Information

Medication	Dose	Directions	Quantity	Refills
☐ Collagenase Santyl® Ointment	250 units/g	Apply a nickel thick layer to wound once daily (or more frequently as the dressing becomes soiled	☐ 7 day supply ☐ 14 day supply ☐ 30 day supply ☐ Other:	

Prescriber Signature and Date (Please sign and date below)

_____ _____

Substitution Permissible Date Dispense as Written Date

"I authorize pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge"

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