* Indicates required field

WOUND CARE ENROLLMENT

Fax to: 512-490-6515

DATE: ____________ SHIP TO: ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
Phone: 512-381-1708
Toll Free: 855-241-6658
11209 Metric Blvd., Suite B4
Austin, TX 78758

PATIENT INFO

*NAME ____________ E-MAIL ____________ *DOB ____________ * ☐ MALE ☐ FEMALE

*ADDRESS ____________ *CITY ____________ *STATE ______ *ZIP ______

*HOME TELEPHONE ____________ ALTERNATE PHONE ____________ SS# ____________

PATIENT INSURANCE INFORMATION: PLEASE FAX A COPY OF THE INSURANCE CARD (FRONT AND BACK)

CLINICAL INFO

* **ICD10 Diagnosis Code:** ☐ ____________ Description: ____________ ☐ Date of Diagnosis: ____________

Allergies? ☐ Latex ☐ Other: ____________ ☐ NKDA

Is the patient currently using prescribed product? ☐ Regranex® ☐ Santyl®

PATIENT DIAGNOSIS

*Are any of the wounds a burn? ☐ Yes ☐ No

Wound Care Plan:		Wound Location:
*Wound #1:	☐ ______ cm x ______ cm	____________
Wound #2:	☐ ______ cm x ______ cm	____________
Wound #3:	☐ ______ cm x ______ cm	____________
Wound #4 :	☐ ______ cm x ______ cm	____________
Wound #5 :	☐ ______ cm x ______ cm	____________
Wound #6 :	☐ ______ cm x ______ cm	____________
Wound #7 :	☐ ______ cm x ______ cm	____________
Other:	☐ ____________	____________

PHYSICIAN INFORMATION

	Prescriber Name:	NPI #:
* ☐	Prescriber Name:	NPI #:
☐	Prescriber Name:	NPI #:
☐	Prescriber Name:	NPI #:
☐	Prescriber Name:	NPI #:
☐	Prescriber Name:	NPI #:
☐	Prescriber Name:	NPI #:
☐	Prescriber Name:	NPI #:
☐	Prescriber Name:	NPI #:

PRESCRIPTION INFORMATION

☐ **REGRANEX® (becaplermin) Gel, 0.01% - Directions** — **Quantity Sufficient:**

☐ Apply a thin layer to affected area daily every 12 hours on, 12 hours off: ____________

☐ 30 day ☐ 60 day ☐ 90 day

☐ Other ____________ **

☐ ____________

☐ Refills ____________

** NOTE: Pharmacy will calculate quantity needed based on number of wounds, wound sizes, and number of days product is needed/days supply

☐ **Collagenase SANTYL® Ointment, 250units/g - 30g/90g - Directions** — **Quantity**

☐ Apply to wound once daily (or more frequently if the dressing becomes soiled) for ______ days.

☐ Dispense quantity sufficient for ______ days**

☐ ____________

☐ Refills ____________

** NOTE: Pharmacy will calculate quantity needed based on number of wounds, wound sizes, and number of days product is needed/days supply

☐ **Other** ____________ **Directions** **Quantity**

☐ ____________ ☐ ____________ ☐ ____________

☐ Other ____________ **

☐ ____________ ☐ Refills ____________

CLINIC INFORMATION

Clinic Name: ____________

Clinic Address: ____________

City ____________ State ______ Zip ______

PRESCRIBER DETAILS - SEE ALL PRESCRIBER DETAILS IN THE SECTION ABOVE: PHYSICIAN INFORMATION

Contact Person: ____________

Telephone: ____________ Fax: ____________ Email: ____________

Office Address: ____________ City: ____________ State: ______ Zip: ______

____________ PRESCRIBER'S SIGNATURE ______ (DATE) * ____________ *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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