Wound Care Enrollment Form

Collagenase SANTYL® Ointment

Phone: 570-346-7319 Fax: 570-343-5850

Andrew Brown's Drug Store
1502 Pittston Avenue
Scranton, PA 18505
www.andrewbrowns.com
570-346-7319
570-343-5850 Fax

TM # ___________

Clinic:______________________________ Clinic Phone: ____________________ Clinic Fax: ________________

Clinic Address (City, State, Zip)______________________________ Prescriber Email: ______________________________

* Indicates required field

PATIENT INFORMATION

*Patient name: ______________________________

*Date of Birth: ____________ *Gender: ☐ M ☐ F SS#: ____________

*Address: ______________________________

____

*City: ______________ *State: ______ *Zip:____________

*Home Phone #: ____________ Alternate Phone #: ____________

Ship to: ☐ **Patient** ☐ **Doctor/Clinic**

PATIENT INSURANCE INFORMATION

PHARMACY BENEFIT PLAN (PBM)

*PBM Name:______________________________

*Policyholder Name:______________________________

*Relationship to Patient:______________________________

*Policy #:______________________________

*PCN #:________________ *Rx BIN #:________________

*PBM Phone #:____________ *Group ID #:________________

*Are any of wounds a burn? ☐ Yes ☐ No

PATIENT DIAGNOSIS

*Diagnosis-Code: ______________________________

Please list any known allergies to medication or other substances:

____

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	____________
*Wound #8: ☐ _____ cm X ____cm	____________
Other: ☐	

PHYSICIAN INFORMATION

	Prescriber	NPI
☐	*Prescriber Name: ______________	NPI #: ____________
☐	*Prescriber Name: ______________	NPI #: ____________
☐	*Prescriber Name: ______________	NPI #: ____________
☐	*Prescriber Name: ______________	NPI #: ____________
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☐	*Prescriber Name: ______________	NPI #: ____________
☐	*Prescriber Name: ______________	NPI #: ____________

PRESCRIPTION INFORMATION

Patient Name: *Date:

Drug: Collagenase SANTYL® Ointment (250 units/g) – 30g/90g

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

*Quantity: ☐ Dispense qty sufficient for _______ days *Refills: ____________

This prescription will be filled generically unless Prescriber Writes "DAW" in the box below.

Dispense as Written

______________________ ______________

Prescriber's Signature Date

Please be advised that I have authorized Andrew Brown's Drug Store and its representatives to act as my authorized agent to initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent. This includes the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data.

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set foth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender or the named addressee.

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PLEASE CONTINUE TO THE NEXT PAGE TO COMPLETE THIS FORM.

Thank you for downloading this Patient Prescription Form.

Instructions:

The highlighted fields in this form can be completed in Adobe Acrobat or Adobe Reader.

1. Complete the appropriate highlighted fields.
2. Save the form to your computer.
3. Print the form.
4. The prescriber must sign and date the form.
5. Fax the completed form to:

570-343-5850

If you do not want to complete the form using your computer, simply print the form, complete the appropriate fields by hand, sign and date the form and fax it to us.

Questions? Call us.

570-346-7319