SANTYL PRESCRIPTION FORM

151 Cochituate Rd | Framingham, MA 01701
Ph 508.202.9993 | 844.7.MYVCARE | Fx 508.202.9343 | Fx 844.230.6211

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

May 2017

Patient Name First Name _____ Last Name _____ SS# _____ DOB _____ Height _____ Weight _____ ☐ Male ☐ Female
Street Address _____ Apt # _____ City _____ State _____ Zip _____
Preferred Language _____ Daytime Tel _____ Evening Tel _____ Cell _____
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ V-Care Pharmacy ☐ Date Needed _____
ICD-10 Diagnosis _____ Is this a burn patient? ☐ Yes ☐ No Allergies _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____
Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Practice Name _____ Office Contact _____
Street Address _____ Suite # _____ City _____ State _____ Zip _____
Tel _____ Fax _____ Email (optional) _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

WOUND CARE PLAN		AREA	WOUND LOCATION	PRESCRIBER	NPI#
☐ Wound 1	_____ cm x _____ cm	_____ cm^2		☐ _____	
☐ Wound 2	_____ cm x _____ cm	_____ cm^2		☐ _____	
☐ Wound 3	_____ cm x _____ cm	_____ cm^2		☐ _____	
☐ Wound 4	_____ cm x _____ cm	_____ cm^2		☐ _____	
☐ Wound 5	_____ cm x _____ cm	_____ cm^2		☐ _____	
☐ Wound 6	_____ cm x _____ cm	_____ cm^2		☐ _____	
☐ Wound 7	_____ cm x _____ cm	_____ cm^2		☐ _____	
☐ Wound 8	_____ cm x _____ cm	_____ cm^2		☐ _____	
☐ Other _____				☐ _____	

MEDICATION	DIRECTIONS	QTY	REFILLS	COMMENTS
☐ **COLLAGENASE SANTYL OINTMENT (250 UNITS/G)**	☐ SIG: 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 ☐ ____ Day Supply	_____	

By signing this form and utilizing our services, you are authorizing V-Care Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

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Please fax completed referral form to **V-Care Pharmacy** at **508.202.9343** or **844.230.6211**

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