REGRANEX PRESCRIPTION REFERRAL FORM

151 Cochituate Rd | Framingham, MA 01701
PHONE: 508-202-9993 | FAX: 508-202-9343 | 844-7-MYVCARE

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name ____________ SS# ____________ D.O.B. ________ Height ________ Weight ________ ☐ Male ☐ Female
Street Address ____________ City ____________ State ________ Zip ________
Preferred Language ____________ Home Phone ____________ Cell Phone ____________
Patient's Usual Pharmacy ____________ Patient Notes ____________

Insured's Name ____________ Relation to Patient ____________ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare # ____________
Prescription Card ☐ Yes ☐ No If yes, Carrier: ________ Phone ____________ Fax ____________ Policy/Group# ____________
BIN# ____________ PCN# ____________ RXID# ____________ RX Group# ____________

Prescriber Name ____________ Practice Name/Office Contact ____________
Street Address ____________ Suite # ________ City ____________ State ________ Zip ________
Prescriber Phone ____________ Prescriber Fax ____________ Prescriber Email ____________

ICD-10 Diagnosis Code: ____________ Allergies: ____________ Wound Care Plan: ____________
Rx's Failed, Dosage, Dates or Therapy, & Reason for Failure: ____________

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		☐	
☐ Other ____________				☐	

MEDICATION	DIRECTIONS	QTY	REFILLS	COMMENTS
☐ **REGRANEX (becaplermin) GEL 0.01%**	☐ SIG: Apply a thin layer to affected area every 12 hours on, 12 hours off.	☐ 30 Day Supply ☐ 60 Day Supply ☐ 90 Day Supply ☐ ____ Day Supply	______	

This is **not** a valid prescription and is intended for reference only. For providers: **Please send a valid prescription electronically or via fax.**

Prescriber's Signature (no stamps) ____________________ **Date** ____________

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