Collagenase SANTYL® Ointment, REGRANEX® Gel Enrollment Form

PATIENT INFORMATION	PRESCRIBER INFORMATION	
Patient Name:	Prescriber Name:	Today's Date:
Date of Birth:	DEA: NPI:	Need By Date:
SSN:	Address:	**Ship To:**
Address:	City, State, ZIP Code:	☐ Patient
City, State, ZIP Code:	Phone: Fax:	☐ ____________
Phone:	Contact Person:	

PRESCRIPTION INSURANCE INFORMATION	PATIENT BILLING INFORMATION
Insurance Plan Type: Rx BIN:	Credit Card: Visa, Mastercard, American Express, Other
Processor Control No. or PCN (if available):	Credit Card Number:
Identification Number:	CCV (last 3-digits):
Rx Group:	Expiration Date (mm/yy):

PRESCRIPTION INFORMATION **www.santyl.com/hcp/dosing-calculator**

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILL
☐ **Santyl**® Ointment	250 units/g	Wound width ______ cm x Wound length ______ cm ☐ Apply to wound as directed once daily (or more frequently if the dressing becomes soiled) for ______ days ☐ ____________________________________ ____________________________________.	_______ gm	1 2 3 4 5 ____

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILL
☐ **Regranex**® Gel	0.01%	Ulcer width ______ cm x Ulcer length ______ cm ☐ Apply a thin, even layer (approximately 1/16 inch) over the entire ulcer area as directed. Cover with saline-moistened gauze dressing. Approximately 12 hours, remove and rinse ulcer with saline or water to remove remaining REGRANEX Gel. ☐ ____________________________________ ____________________________________.	_____ x 15 gm	1 2 3 4 5 ____

OTHER MEDICATIONS

OTHER	STRENGTH	DIRECTIONS	QTY	REFILL
☐ ____________		☐ ____________________________________	__________	1 2 3 4 5 ____
☐ ____________		☐ ____________________________________	__________	1 2 3 4 5 ____

CURRENT PHARMACY INFORMATION *to be contacted if we have any issues when billing insurance
Pharmacy Name:
Pharmacy Phone Number:
Pharmacy Fax Number:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Newport Lido Pharmacy to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

☐ **Do Not Substitute**

Prescriber Signature: ____ **Date:** ________________

Newport Lido Pharmacy
351 Hospital Road, Newport Beach, CA 92663
Phone: 949-764-6580
Fax: 949-764-6581

IMPORTANT NOTICE: This fascimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it's received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and phone number set forth herein and obtain instructions as to disposal of the material. In no event should material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. 140625PT