Rexall
Dania Pharmacy & Medical Supply

REGRANEX ORDER FORM

Please Fax Orders to : 954-304-9703

FACILITY INFORMATION

Facility Name:	**Facility Contact:**
	Facility Phone:
	Facility Fax:

PATIENT INFORMATION:

Last Name:	**First and Middle Name:**	**Date of Birth:**

WOUND CARE PLAN

Wound # Wound Size	Location	Grams Needed	Prescription Order
Wound 1 _____cm x _____			**Regranex Becaplermin Gel 0.01%**
Wound 2_____cm x _____			**Apply to wound area once daily**
Wound 3 _____cm x _____			**Total Grams requested:** / **Refills (CIRCLE)** 1 2 3 4 5 6 7 8 9 10 11
			Days Supply:
DIAGNOSIS CODE _____			**Note to Pharmacy:**

PHYSICIAN INFORMATION:

Prescriber Name:	**Prescriber NPI:**	**Prescriber phone:**

Prescriber signature:	**Date:**

WOUND CALCULATION GUIDE

Wound area	30 days therapy
up to 8 cm^2	15 grams = 1 tube
9-16 cm^2	30 grams = 2 tubes
17-24 cm^2	45 grams = 3 tubes
25-32 cm^2	60 grams = 4 tubes
33-40 cm^2	75 grams = 5 tubes
40-48 cm^2	90 grams = 6 tubes

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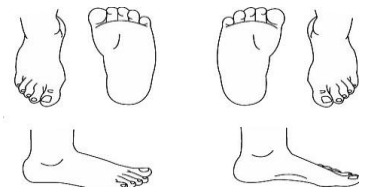

Please Indicate the location of the wound(s)

Is there a neoplasm at the intended site of application? Y / N

Is the requested drug being prescribed for the treatment of a lower extremity diabetic neuropathic ulcer that extends into the subcutaneous tissue or beyond and has an adequate blood supply? Y / N

Is treatment given in combination with wound care (i.e. debridement, infection control, and/or pressure relief) Y / N

Previously tried treatments and duration? (Describe)

DISCHARGE INFORMATION

Discharge Location:	**Discharge Contact:**
	Discharge Phone:
	Discharge Fax:

Regranex Dosing Calculator is Available at www.regranex.com/easy-dosing