Medical Center
PHARMACY
Service Delivery Trust Since 1924

Santyl® Home Health Referral

Phone # 1-844-546-7577 • 619-263-1998
Fax # 1-844-240-2518 • 619-243-3245

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

Patient Name: | Date of Birth: | ☐ Male ☐ Female

Address: | City: | State: | Zip:

Phone Number: | Alternate Phone Number: | Language:

Social Security Number: | E-Mail:

Allergies: ☐ NKDA

Pick Up / Ship to: ☐ Patient ☐ Office ☐ Alternative Address:

INSURANCE INFORMATION **If available, please fax copy of prescription insurance cards with this form (front and back).**

PRESCRIBER INFORMATION

Practice Name:

Office Contact:

Practice Address: | City: | State: | Zip:

Phone Number: | Fax Number:

HOME HEALTH REFERRAL INFORMATION

Referring Agency: | Referring Provider/Nurse:

Referring Agency Address: | Referring Agency Phone Number:

Referring Agency City: | Referring Agency Fax:

Referring Agency State: | Referring Agency Zip: | Referring Agency Notes:

CLINICAL INFORMATION

Diagnosis code: | Is this a burn patient? ☐ Yes ☐ No

Comments/Notes:

Wound Care Plan	Wound Location	Prescriber
☐ Wound 1 _________ cm x __________ cm		☐ ________________________ NPI: _______________
☐ Wound 2 _________ cm x __________ cm		☐ ________________________ NPI: _______________
☐ Wound 3 _________ cm x __________ cm		☐ ________________________ NPI: _______________
☐ Wound 4 _________ cm x __________ cm		☐ ________________________ NPI: _______________
☐ Wound 5 _________ cm x __________ cm		☐ ________________________ NPI: _______________
☐ Wound 6 _________ cm x __________ cm		☐ ________________________ NPI: _______________
☐ Other:		☐ ________________________ NPI: _______________

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
☐ Collagenase Santyl® Ointment	250 units/g	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 ☐ Other:	

PATIENT SUPPORT PROGRAMS: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Physician Signature: **Date:**

Dispense as written | **Date** | **Substitution Premissable** | **Date**

I authorize Medical Center Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions:________

There are 1 of 4 options for you when finding our company: 1. NPI # - 1821395609, 2. NCPDP # - 5640289
3. Company Name: Community Medical Center Pharmacy, 4. Company Address: 610 Gateway Center Way, San Diego, CA 92102