



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

Clinic: _____ Clinic Phone: _____ Clinic Fax: _____

Clinic Address (City State, Zip): _____ Prescriber Email: _____

* Indicates required field

PATIENT INFORMATION	PATIENT INSURANCE INFORMATION
<p>*Patient Name: _____</p> <p>*Date of Birth: _____ *Gender: <input type="checkbox"/> M <input type="checkbox"/> F SS# _____</p> <p>*Address: _____</p> <p>*City: _____ *State: _____ *Zip: _____</p> <p>*Home Phone #: _____ Alternate Phone #: _____</p> <p>Ship to: <input type="checkbox"/> Patient</p> <p>*Are any of your wounds a burn?: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>PHARMACY BENEFIT PLAN (PBM)</p> <p>*PBM Name: _____</p> <p>*Policyholder Name: * _____</p> <p>Relationship to Patient: _____</p> <p>*Policy #: _____</p> <p>*PCN #: _____ *Rx BIN #: _____</p> <p>*PBM Phone #: _____ *Group ID #: _____</p>

PATIENT DIAGNOSIS	PRESCRIBER INFORMATION
<p>*Diagnosis-Code: _____</p> <p>Please list any known allergies to medication or other substances: _____</p> <p>Wound care plan: _____ Wound Location: _____</p> <p>*Wound #1: <input type="checkbox"/> _____ cm x _____ cm _____</p> <p>*Wound #2: <input type="checkbox"/> _____ cm x _____ cm _____</p> <p>*Wound #3: <input type="checkbox"/> _____ cm x _____ cm _____</p> <p>*Wound #4: <input type="checkbox"/> _____ cm x _____ cm _____</p> <p>*Wound #5: <input type="checkbox"/> _____ cm x _____ cm _____</p> <p>Other: <input type="checkbox"/> _____</p>	<p><input type="checkbox"/> *Prescriber Name: _____ NPI #: _____</p> <p><input type="checkbox"/> *Prescriber Name: _____ NPI #: _____</p> <p><input type="checkbox"/> *Prescriber Name: _____ NPI #: _____</p> <p><input type="checkbox"/> *Prescriber Name: _____ NPI #: _____</p> <p><input type="checkbox"/> *Prescriber Name: _____ NPI #: _____</p> <p><input type="checkbox"/> *Prescriber Name: _____ NPI #: _____</p> <p><input type="checkbox"/> *Prescriber Name: _____ NPI #: _____</p> <p><input type="checkbox"/> *Prescriber Name: _____ NPI #: _____</p> <p><input type="checkbox"/> *Prescriber Name: _____ NPI #: _____</p>

PRESCRIPTION INFORMATION	
Patient Name: _____	*Date: _____
Drug: Collagenase SANTYL [®] Ointment (250 units/g) - 30g/90g	*Sig: Apply to wound once daily (or more frequently if the dressing becomes soiled) for _____ days.
*Quantity: <input type="checkbox"/> Dispense qty sufficient for _____ days	*Refills: _____
Drug: Regranex [®] (becaplermin) Gel, 0.01%	*Sig: (Directions) Apply thin layer of affected area daily every 12 hours on, 12 hours off:
*Quantity: <input type="checkbox"/> 30 day supply <input type="checkbox"/> 60 day supply <input type="checkbox"/> 90 day supply <input type="checkbox"/> Other: _____	*Refills: _____

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/CHIMOVIT 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

