Medical Center PHARMACY
Service Delivery Trust Since 1924

Regranex Gel and/or SANTYL Ointment

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.

Clinic:_____ Clinic Phone:_____ Clinic Fax:_____

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

*Indicates required field

PATIENT INFORMATION

*Patient Name:

*Date of Birth: *Gender: ☐ M ☐ F SS#

*Address:

*City: *State: *Zip:

*Home Phone #: Alternate Phone #:

Ship to: ☐ **Patient**

*Are any of your wounds a burn?: ☐ Yes ☐ No

PATIENT INSURANCE INFORMATION

PHARMACY BENEFIT PLAN (PBM)

*PBM Name:

*Policyholder Name: *

Relationship to Patient:

*Policy #:

*PCN #: *Rx BIN #:

*PBM Phone #: *Group ID #:

PATIENT DIAGNOSIS

*Diagnosis-Code:

Please list any known allergies to medication or other substances:

Wound care plan: Wound Location:

*Wound #1: ☐ ____ cm x ____ cm _____

*Wound #2: ☐ ____ cm x ____ cm _____

*Wound #3: ☐ ____ cm x ____ cm _____

*Wound #4: ☐ ____ cm x ____ cm _____

*Wound #5: ☐ ____ cm x ____ cm _____

Other: ☐

PRESCRIBER INFORMATION

☐ *Prescriber Name: _____ NPI #:_____

☐ *Prescriber Name: _____ NPI #:_____

☐ *Prescriber Name: _____ NPI #:_____

☐ *Prescriber Name: _____ NPI #:_____

☐ *Prescriber Name: _____ NPI #:_____

☐ *Prescriber Name: _____ NPI #:_____

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☐ *Prescriber Name: _____ NPI #:_____

☐ *Prescriber Name: _____ NPI #:_____

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: ☐ 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: ☐ 30 day supply ☐ 60 day supply ☐ 90 day supply ☐ 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**

# 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