



WOUND CARE HOME HEALTH FORM

Fax To: 817-332-5363

PHARMACY LOCATION
Phone: 817-335-5712
Fax: 817-332-5363
800 8th Avenue, Suite 130
Fort Worth, TX 76104

DATE: _____ SHIP TO:
DATE NEEDED: _____ PATIENT OFFICE

* Indicates required field

PATIENT INFO
*NAME _____ E-MAIL _____ *DOB _____ *MALE FEMALE
*ADDRESS _____ *CITY _____ *STATE _____ *ZIP _____
*HOME TELEPHONE _____ ALTERNATE PHONE _____ SS# _____

CLINICAL INFO
Patient Insurance Information: Please fax a copy of the insurance card (front and back)
* ICD10 Diagnosis Code: _____ Description: _____ Date of Diagnosis: _____
Allergies? Latex Other: _____ NKDA
Is the patient currently using Santyl®? Yes No

PATIENT DIAGNOSIS
*Are any of the wounds a burn? Yes No
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
Wound #6: _____ cm x _____ cm
Wound #7: _____ cm x _____ cm
Wound #8: _____ cm x _____ cm
Other: _____

HOME HEALTH REFERRAL INFORMATION
* Referring Agency: _____
*Agency Zip Code: _____
Referring Provider/Nurse: _____
Provider/Nurse Phone #: _____

PHYSICIAN INFORMATION
* Prescriber Name: _____ NPI #: _____
Prescriber Name: _____ NPI #: _____
Prescriber Name: _____ NPI #: _____
Prescriber Name: _____ NPI #: _____
Prescriber Name: _____ NPI #: _____

PRESCRIPTION INFORMATION
Collagenase SANTYL® Ointment Directions Quantity
(250 units/g) - 30g/90g Apply to wound once daily (or more frequently if the dressing becomes soiled) for _____ days. Dispense quantity sufficient for _____ days**
May substitute May NOT substitute Refills _____
** NOTE: Pharmacy will calculate quantity needed based on number of wounds, wound sizes, and number of days product is needed/days supply
Other Directions Quantity
May substitute May NOT substitute Refills _____

CLINIC INFORMATION
Clinic Name: _____
Clinic Address: _____
City _____ State _____ Zip _____

PRESCRIBER DETAILS
Prescriber's Name: _____ Contact Person: _____
Telephone: _____ Fax: _____ Email: _____
Office Address: _____ City: _____ State: _____ Zip: _____
NPI #: _____ DEA #: _____ TAX ID #: _____ Medicaid Provider #: _____

PRESCRIBER INFORMATION
PRESCRIBER'S SIGNATURE _____ (DATE) _____ *IF BRAND DRUGS ARE PREFERRED, HANDWRITE "BRAND MEDICALLY NECESSARY" ABOVE
I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
IMPORTANT NOTICE: This facsimile 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 is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. For information about the privacy practices of Omnicell, Inc. and its wholly owned subsidiaries or to opt-out certain uses of your personal information, please visit https://www.omnicell.com/privacy-notice.