

SANTYL[®] REFERRAL FORM

Phone 877.794.9833 Fax 855.861.4941
10004 S. 152nd St, Suite C, Omaha NE 68138



Patient Information				PLEASE FAX INSURANCE CARD (FRONT AND BACK)				Prescriber Information			
Last Name		First Name		DOB		Practice/Facility Name					
Address						Address					
City		State		ZIP		City		State	ZIP		
Phone			SSN			Prescriber Name					
Allergies						Prescriber NPI					
Sex	Male	Female	Weight (kg)		Height (ft.in)		Nurse/Key Contact		Phone/Pager		
Insurance Plan			Plan ID #			Fax		Email			

Diagnosis/Clinical Information				PLEASE FAX CLINICAL AND LAB INFORMATION			
Primary Diagnosis: _____				Is this a burn patient?		Yes	No
Comments/notes:							

Additional Information			
Today's Date	Delivery Date	Deliver to: Home Prescriber	Special Instructions

Prescription			
Wound Care Plan		Area	Wound Location
Wound 1	_____ x _____ cm	_____ cm ²	
Wound 2	_____ x _____ cm	_____ cm ²	
Wound 3	_____ x _____ cm	_____ cm ²	
Wound 4	_____ x _____ cm	_____ cm ²	
Wound 5	_____ x _____ cm	_____ cm ²	
Wound 6	_____ x _____ cm	_____ cm ²	
Wound 7	_____ x _____ cm	_____ cm ²	
Wound 8	_____ x _____ cm	_____ cm ²	
Other			

MEDICATION	DIRECTIONS	QTY	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 _____ Day Supply	
Other: _____			

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution:

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)

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