SANTYL® REFERRAL FORM

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

Pharmacy HyVee SOLUTIONS

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies		
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
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)