Wound Care

Worcester, MA: **toll free** (855) 880-1091 **toll free fax** (844) 265-0265

www.allcarepluspharmacy.com

PATIENT INFO	PRESCRIBER INFO
Patient Name	Prescriber Name
Address	Group/Hospital
City, State, Zip	Address
Phone	City, State, Zip
Social Security	Phone Fax
Date of Birth	DEA/NPI #
Gender ☐ Male ☐ Female	Preparer Name/Office Contact

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

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: ____

Diagnosis Code:

____

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

Please list any known allergies to medication or other substances:

____

____

____

PRESCRIPTION INFORMATION

DRUG	DOSAGE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ **Collagenase SANTYL® Ointment**	(250/units/g)-30g/90g	Apply to wound once daily (or more frequently if the dressing becomes soiled) for _______ days	Dispense qty sufficient for _________ days	_________

Physician Signature: ______________________________ Date: _______________

I authorize AllCare Plus pharmacy 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 the material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. This is a patient enrollment form for the above mentioned therapies. Patients have the right to use the pharmacy of their choice, if AllCare PLUS Pharmacy is the Pharmacy of choice, please follow up with a call in, faxed or mailed prescription to AllCare PLUS Pharmacy 12 Plymouth Street Worcester MA 01608. (PH) 1 855 880 1091 (FAX) 1 844 265 0265