

Patient Information

Patient Name:			Date of Birth:		<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		City:	State:	Zip:	
Phone Number:		Alternate Phone Number:		Language:	
Social Security Number:			E-Mail:		
Allergies:					<input type="checkbox"/> NKDA
<input type="checkbox"/> Pick Up / Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Alternative Address:					

Insurance: Please fax copy of insurance card (front and back)

Prescriber Information

Practice Name:				
Office Contact:				
Practice Address:		City:	State:	Zip:
Phone Number:		Fax Number:		

Clinical Information

Diagnosis code:	Is this a burn patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Comments/Notes:

Wound Care Plan	Wound Location	Prescriber
<input type="checkbox"/> Wound 1 _____ cm x _____ cm		<input type="checkbox"/> _____ NPI: _____
<input type="checkbox"/> Wound 2 _____ cm x _____ cm		<input type="checkbox"/> _____ NPI: _____
<input type="checkbox"/> Wound 3 _____ cm x _____ cm		<input type="checkbox"/> _____ NPI: _____
<input type="checkbox"/> Wound 4 _____ cm x _____ cm		<input type="checkbox"/> _____ NPI: _____
<input type="checkbox"/> Wound 5 _____ cm x _____ cm		<input type="checkbox"/> _____ NPI: _____
<input type="checkbox"/> Wound 7 _____ cm x _____ cm		<input type="checkbox"/> _____ NPI: _____
<input type="checkbox"/> Other:		<input type="checkbox"/> _____ NPI: _____

Prescription Information

Medication	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Collagenase Santyl® Ointment	250 units/g	Apply a nickel thick layer to wound once daily (or more frequently as the dressing becomes soiled)	<input type="checkbox"/> 7 day supply <input type="checkbox"/> 14 day supply <input type="checkbox"/> 30 day supply <input type="checkbox"/> Other:	
<input type="checkbox"/> Regranex® Gel	0.01%	Apply a thin layer to affected area. Cover with saline moistened gauze for 12 hours. After 12 hours, remove medication using saline or water. Cover ulcer with new saline moistened dressing (without gel). Repeat daily.	<input type="checkbox"/> 7 day supply <input type="checkbox"/> 14 day supply <input type="checkbox"/> 30 day supply <input type="checkbox"/> Other:	

Prescriber Signature and Date (Please sign and date below)

Substitution Permissible _____ Date _____ Dispense as Written _____ Date _____

"I authorize Curexa™ and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge"