Send Electronic Prescriptions (EScript) to:
NPI # 1962891762
ASP Cares
13988 Diplomat Dr, Ste. 100B, Farmers Branch, TX, 75234
Ph: (214) 919-2090
Fax: 1 (888) 294-9434

WOUND CARE ENROLLMENT FORM

*Rep Name:*_____

PATIENT INFORMATION

Patient Name:_____
Date of Birth:_____Gender: ☐ M ☐ F
Address:_____
_____
City:_____State:_____Zip:_____
Home Phone #:_____Alternate Phone #:_____
Ship to: ☐ Patient ☐ Other:_____
Are any of the wounds a burn? ☐ Yes ☐ No

PATIENT INSURANCE INFORMATION

PHARMACY BENEFIT PLAN (PBM)
PBM Name:_____
Policyholder Name:_____
Relationship to Patient:_____
PBM Phone #:_____
Policy or RID #:_____Group #:_____
Rx BIN #:_____PCN #:_____

PATIENT DIAGNOSIS

Diagnosis-Code:_____
Please list any known allergies to medication or other substances:
_____

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: ☐ _____	

PRESCRIBER INFORMATION

Clinic Name:
Clinic Phone: Clinic Fax:
Clinic Address:

Prescriber	NPI
☐ _____	_____
☐ _____	_____
☐ _____	_____
☐ _____	_____
☐ _____	_____
☐ _____	_____

Notes
_____
_____

PRESCRIPTION INFORMATION

Date:_____

SANTYL OINTMENT

Drug: ☐ **Collagenase SANTYL Ointment (250 units/g):** ☐ 30g ☐ 90g
Quantity: ☐ Dispense qty sufficient for ☐ 30 days ☐ 90 days
Refills:_____
Sig: Apply to wound once daily (or more frequently if the dressing becomes soiled for _____days

REGRANEX GEL

Drug: ☐ **Regranex Gel:** 0.01%
Quantity: ☐ Dispense qty sufficient for _____days
Refills:_____
Sig: _____

Additional Drug(s) Needed: (if any)
Drug:_____Qty:_____Sig:_____

PROVIDER SIGNATURE

☐ May substitute ☐ May **NOT** substitute

Prescriber's Signature(NO STAMPS):_____Date of Signature:_____

PLEASE FAX COMPLETED FORM TO: 1 (888) 294-9434