

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   |
|--------------------------------|-------|
| <input type="checkbox"/> _____ | _____ |
| <input type="checkbox"/> _____ | _____ |
| <input type="checkbox"/> _____ | _____ |
| <input type="checkbox"/> _____ | _____ |
| <input type="checkbox"/> _____ | _____ |
| <input type="checkbox"/> _____ | _____ |

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: \_\_\_\_\_

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Co-payments due at dispensing of the medication