Giant Eagle Specialty Pharmacy

Phone: 844-259-1891
Fax: 877-645-4142

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#8991)
2500 Lovi Road
Freedom, PA 15042

WOUND CARE ENROLLMENT FORM

Today's Date: _____

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**_____ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: _____ ☐ Male ☐ Female DOB:_____
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Best Phone Number: _____ Alternate Phone Number: _____
Height:_____ Weight: _____ ☐ kgs. or ☐ lbs. Recorded Date: _____
Caregiver: _____ Allergies: _____
Store Preference (address): _____
Diagnosis: _____ ICD Code: _____ ☐ F10_____ ☐ F11_____
Emergency Contact Name: _____ Emergency Contact Phone #: _____

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

Carrier: _____ PCN #: _____Group: _____
Card: _____ BIN: _____

Prescription Information

☐ **Collagenase SANTYL® Ointment** 250 units/gram Quantity sufficient for _____ days Number of Refills: _____
Directions: Apply to wound once a day (or more frequently if the dressing becomes soiled) for _____ days

Primary Diagnosis: _____
ICD-10 Code: _____
Secondary Diagnosis: _____
ICD-10 Code: _____
Is patient currently using SANTYL®? ☐ Yes ☐ No
SANTYL® is being prescribed to treat burns? ☐ Yes ☐ No

☐ Wound #1 ____ cm x ____ cm Location _____
☐ Wound #2 ____ cm x ____ cm Location _____
☐ Wound #3 ____ cm x ____ cm Location _____
☐ Wound #4 ____ cm x ____ cm Location _____
☐ Wound #5 ____ cm x ____ cm Location _____
☐ Wound #6 ____ cm x ____ cm Location _____
☐ Wound #7 ____ cm x ____ cm Location _____
☐ Wound #8 ____ cm x ____ cm Location _____
☐ Other _____ Location _____

☐ Physician _____
NPI _____
☐ Physician _____
NPI _____
☐ Physician _____
NPI _____
☐ Physician _____
NPI _____
☐ Physician _____
NPI _____
☐ Physician _____
NPI _____
☐ Physician _____
NPI _____
☐ Physician _____
NPI _____

Deliver to: ☐ Patient's home ☐ 1st dose to physician's office - remaining to patient home ☐ Physician's Office
☐ Giant Eagle Pharmacy _____

Prescriber Information

Date Prescription Needed: _____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #:_____ NPI #: _____
Office Address: _____ City: _____ State: _____ ZIP: _____
State License #: _____DEA #: _____Tax ID #:_____
In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below.
_____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: _____ **Date:** _____