CENTURY SPECIALTY SCRIPT

*Indicates required field

SANTYL Enrollment Form

Customer Service: (800) 521-3949
Fax completed form to: (877) 521-5353
E-prescribing: Century Specialty Script
6 Fisher Ave. Tuckahoe, NY 10707

Prescriber information

*Prescriber name:

*Email[1]:

*NPI #: Tax ID #:

*Prescriber phone #: *Fax #:

*Address:

*City: *State: *Zip:

*Office contact name:

Home health agency name (if applicable):

Patient information

*Patient name (first last):

*Date of Birth: *Gender: M ☐ F ☐

*Address:

*City: *State: *Zip:

*Home phone #: Alternate phone #:

SSN (Last 4 digits):

Email:

Ship to: ☐ Patient ☐ MD Office ☐ Other _____

Emergency contact: Phone #:

Patient's local pharmacy name:

Address:

Phone #:

Prescription information

*Patient name (first last):

*Drug: **Collagenase SANTYL Ointment 250 units/g** *Date:

*Quantity sufficient: ☐ 30 days supply ☐ 60 days supply ☐ 90 days supply

*Sig (Directions): Apply a nickel thick layer to the affected area(s) once daily as directed

*Refills:

Notes:

Patient insurance information/Pharmacy benefit plan

Fill in fields with pharmacy benefits – NOT medical. OR... Fax demographic sheet or patient's pharmacy benefits card along with enrollment form.

*Name: Pharmacy help desk #:

Policyholder name: Relationship to patient:

*Member ID #: *Group ID #:

*Rx BIN #: *PCN #:

Patient diagnosis

*Diagnosis code:

Please list any known allergies to medication or other substances: ☐ NKDA:

Treatments failed, dosage, dates of therapy and reason for failure:

Wound care plan:

Wound location	Width	Length	
Location #1:			☐ cm ☐ mm ☐ in
Location #2:			☐ cm ☐ mm ☐ in
Location #3:			☐ cm ☐ mm ☐ in

Provider attestation

By signing below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that Century Specialty Script (CSS) reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. Finally, I authorize CSS as my designated agent to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment. Finally, I allow CSS to email me regarding prescription status updates and act as my prior authorization agent in dealing with prescription and medical insurance companies.

☐ **Please send me status updates via email/fax.** You may opt to receive emails from CSS regarding the status of your patient's prescription. By agreeing to receive emails from CSS, you acknowledge that CSS will send standard emails to you via the Internet. Therefore, there is potential for these unencrypted emails to be intercepted by unauthorized third parties. If you share your email account or computer with others, those parties may be able to access your confidential information. You should notify CSS immediately if you wish to cease receiving emails or if your email address changes. You should not use emails for emergencies.

*Prescriber's signature:

Signature is required to process the prescription. Stamped signatures are not permissible.

(Dispense as written)

*Date of signature:

smith&nephew