Santyl (collagenase) Prior Authorization Request Form

Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____

MEMBER'S FIRST NAME: _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION			
LAST NAME:	FIRST NAME:		
PHONE NUMBER:	DATE OF BIRTH:		
STREET ADDRESS:			
CITY:	STATE: ZIP CODE:		
PATIENT INSURANCE ID NUMBER:			
MALE FEMALE HEIGHT (IN/CM): WEIGHT (LB/KG): ALLERGIES:			

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: <u>PRIMETHERAPEUTICS.COM/NOPP</u>

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): ______

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION			
LAST NAME:	FIRST NAME:		
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:		
NPI NUMBER:	DEA NUMBER:		
PHONE NUMBER:	FAX NUMBER:		
STREET ADDRESS:			
CITY:	STATE: ZIP CODE:		
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:		

MEDICATION OR MEDICAL DISPENSING INFORMATION					
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:		
NEW THERAPY		IF RENEWAL: DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):					

Continued on next page.



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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? YES (if yes, complete below) NO MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): DURATION OF THERAPY (SPECIFY DATES): RESPONSE/REASON FOR FAILURE/ALLERGY: 2. LIST DIAGNOSES: LOD-10: Wound debridement	MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
DRUG NAME AND DOSAGE): DATES): FAILURE/ALLERGY: 2. LIST DIAGNOSES: ICD-10: Wound debridement Other diagnosis: ICD-10. 3. REQURED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION. PRIOR AUTHORIZATION. Clinical Information: Is the drug going to be used in conjunction with a clinical trial? Yes □ No Is patient using Santyl for wound debridement? Yes □ No No Does patient require more than the quantity limit of #60Gms per a 30-day supply? Yes □ No Please provide documentation. Does patient require more than once a day dressing changes? Yes □ No Please provide documentation. Is the wound size bigger than 3cm width and/or length? Yes □ No Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? Information is received. ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form. Prescriber Signature or Electronic I.D. Verification: Date:	1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) 📃 NO		
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MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program					

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811

