

## SANTYL OINTMENT (collagenase) PRIOR AUTHORIZATION FORM

Prior authorization guidelines are accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	total # pages: _____	
<input type="checkbox"/> Renewal request	PA# _____	Prescriber name: _____	
Name & phone # of office contact: _____		Prescriber's NPI: _____	
Name & phone # of facility contact: _____		State licence #: _____	
RECIPIENT INFORMATION		Street address: _____	
Recipient Name: _____		Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____

### CLINICAL INFORMATION

<b>Medication requested:</b> Santyl Ointment	Quantity: _____ grams	Refills: _____
Diagnosis ( <i>submit documentation</i> ): _____		Dx code ( <i>required</i> ): _____

#### ALL requests

1. Does the recipient have one of the following diagnoses? *Check all that apply.*

<input type="checkbox"/> severe burn	<input type="checkbox"/> venous ulcer	<input type="checkbox"/> Yes – <i>Submit documentation.</i>
<input type="checkbox"/> pressure ulcer	<input type="checkbox"/> diabetic ulcer	<input type="checkbox"/> No – <i>Submit medical literature documentation supporting the use of Santyl Ointment for the recipient's diagnosis.</i>
2. What is the prescriber's specialty? *Check all that apply.*

<input type="checkbox"/> burn/wound care	<input type="checkbox"/> surgeon	<input type="checkbox"/> podiatrist	<input type="checkbox"/> burn/wound care facility	<input type="checkbox"/> other ( <i>specify</i> ): _____
--	----------------------------------	-------------------------------------	---	--
3. Does the recipient have documentation of an initial evaluation performed by a burn or wound care specialist that includes all of the following? *Check all items included in documented evaluation.*

<input type="checkbox"/> wound history	<input type="checkbox"/> wound surface area & depth	<input type="checkbox"/> assessment for signs & symptoms of infection	<input type="checkbox"/> Yes <i>Submit documentation of initial evaluation.</i>
<input type="checkbox"/> wound location	<input type="checkbox"/> presence of necrotic tissue	<input type="checkbox"/> prognosis for healing	<input type="checkbox"/> No
4. Complete the following (based on current state of recipient's wound) and *submit documentation for each.*

Eschar/slough (non-viable tissue): _____ %	Granulation tissue: _____ %	Epithelial tissue: _____ %
Wound size: _____ cm X _____ cm	Length of time wound has been present: _____ days / weeks / months	
5. *Submit documentation* of all agents currently being used on the recipient's wound (cleaners, antimicrobials, dressings, etc).

#### RENEWAL requests for wounds PRESENT FOR MORE THAN 3 MONTHS

1. Does the recipient have a documented evaluation of the following? *Check all that apply and submit documentation.*

<input type="checkbox"/> prognosis for complete healing and resolution of the wound	<input type="checkbox"/> wound biopsy
---	---------------------------------------
2. Has the recipient been evaluated and treated for nutritional deficiencies?

<input type="checkbox"/> Yes	<i>Submit documentation of evaluation and, if applicable, corrective measures taken.</i>
<input type="checkbox"/> No	
3. Does the recipient have documentation of an assessment of the wound for presence of infection, including a gram stain or wound culture?

<input type="checkbox"/> Yes	<i>Submit documentation.</i>
<input type="checkbox"/> No	
4. Is the wound infected?

<input type="checkbox"/> Yes – <i>submit documentation of treatment regimen.</i>
<input type="checkbox"/> No – <i>submit documentation.</i>
5. Have other methods of debridement been tried on the wound, or does the recipient have any contraindications or intolerances to other methods of debridement?

<input type="checkbox"/> Yes	<i>Submit documentation.</i>
<input type="checkbox"/> No	
6. *Check all that apply* to the recipient and *submit documentation* for all items checked.

<input type="checkbox"/> limited mobility	<input type="checkbox"/> decreased blood flow to wound area	<input type="checkbox"/> immunocompromised
---	---	--
7. *Submit documentation of the following:*

<input type="checkbox"/> recipient's complete current medication list	<input type="checkbox"/> all comorbid medical conditions
<input type="checkbox"/> other methods & treatments being used to promote wound healing	

### PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
-----------------------------	-------------

**Confidentiality Notice:** The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.