

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

Medication requested: 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>): _____
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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
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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
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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: _____
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