Prescriber Criteria Form
Santyl 2026 PA Fax 6870-A v1 010126.docx
Santyl (collagenase)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Santyl (collagenase).

Drug Name:
Santyl (collagenase)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed to debride chronic dermal ulcers and severely burned areas? [If no, then no further questions.]	Yes	No
2	Is this a request for a continuation of therapy? [If no, then no further questions.]	Yes	No
3	Has the wound been evaluated since beginning treatment with the requested drug? [If no, then no further questions.]	Yes	No
4	Is granulation tissue well established in the wound?	Yes	No

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____