

# McKesson Patient Care Solutions Inc.

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## DERMATOLOGY PRODUCT ORDER FORM

<b>INTERNAL USE</b>	Rep # _____
	Ref # _____
	Tracking ID # _____

### PLEASE PROVIDE A FACESHEET WITH PATIENT DEMOGRAPHICS WITH INITIAL ORDER

<b>PATIENT</b>	First Name _____ Last Name _____ <input type="checkbox"/> M <input type="checkbox"/> F DOB _____
	Address _____ Phone _____ Alternate Phone _____
	City _____ State _____ Zip _____ Email _____
<b>PRESCRIPTION VALID FOR:</b> <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <b>START DATE</b> ____/____/____ <b>DISPENSE:</b> <input type="checkbox"/> 30 day supply <input type="checkbox"/> 2 week supply <b># OF REFILLS:</b> ____	

<b>REF</b>	Referral _____
	Contact _____ Phone _____
	How would you prefer to be contacted: <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Fax _____

<b>DIAG</b>	<b>ICD-10 DIAGNOSIS CODE (REQUIRED)</b>
	<b>PERCENT OF BODY COVERED IN EB WOUNDS</b>

<b>DISPENSING ORDER INFORMATION</b>	<b>ALGINATE DRESSING</b>		<b>QTY</b>	<b>GAUZE</b>		<b>QTY</b>
	<input type="checkbox"/> Calcium Alginate	<input type="checkbox"/> 2x2 <input type="checkbox"/> 4x4 <input type="checkbox"/> 4x8 <input type="checkbox"/> Rope		<input type="checkbox"/> Adaptic	<input type="checkbox"/> 3x3 <input type="checkbox"/> 3x8	
	<input type="checkbox"/> Silver Alginate	<input type="checkbox"/> 2x2 <input type="checkbox"/> 4x5 <input type="checkbox"/> 4 1/4 x 4 1/4 <input type="checkbox"/> Rope		<input type="checkbox"/> Bioguard Roll Gauze	<input type="checkbox"/> 2" <input type="checkbox"/> 3" <input type="checkbox"/> 4"	
	<b>COLLAGEN</b>		<b>QTY</b>	<input type="checkbox"/> Gauze	<input type="checkbox"/> 2x2 <input type="checkbox"/> 4x4 <input type="checkbox"/> 4x8	
	<input type="checkbox"/> Puracol	4x4.25		<input type="checkbox"/> Gauze AMD	<input type="checkbox"/> 2x2 <input type="checkbox"/> 4x4	
	<input type="checkbox"/> Puracol AG	4x4.25		<input type="checkbox"/> Iodoform Packing Gauze	<input type="checkbox"/> 1/4" <input type="checkbox"/> 1/2" <input type="checkbox"/> 1"	
	<input type="checkbox"/> Endoform	2x2		<input type="checkbox"/> Kerlix Roll Gauze	<input type="checkbox"/> 3" <input type="checkbox"/> 4" (AMD <input type="checkbox"/> )	
	<input type="checkbox"/> Promogran	2x2		<input type="checkbox"/> Mesalt	<input type="checkbox"/> 2x2 <input type="checkbox"/> 3x3 <input type="checkbox"/> 8x8 <input type="checkbox"/> Ribbon	
	<input type="checkbox"/> Prisma AG	2x2		<input type="checkbox"/> Non Woven Gauze	4x4 (200 per/sleeve)	
	<b>COMPRESSION DRESSING</b>		<b>QTY</b>	<input type="checkbox"/> Roll Gauze Conform	<input type="checkbox"/> 2" <input type="checkbox"/> 3" <input type="checkbox"/> 4" <input type="checkbox"/> 6"	
	<input type="checkbox"/> Coban/Coflex	<input type="checkbox"/> 1" <input type="checkbox"/> 2" <input type="checkbox"/> 3" <input type="checkbox"/> 4" <input type="checkbox"/> 6"		<input type="checkbox"/> Telfa	<input type="checkbox"/> 3x4 (AMD <input type="checkbox"/> ) <input type="checkbox"/> 3x8 (AMD <input type="checkbox"/> )	
	<b>FOAM DRESSING</b>		<b>QTY</b>	<input type="checkbox"/> Vaseline Gauze	<input type="checkbox"/> 3x9 <input type="checkbox"/> 3x18 <input type="checkbox"/> 6x36	
	<input type="checkbox"/> Biatain Soft-Hold	<input type="checkbox"/> 2x2 3/4 <input type="checkbox"/> 4x4 <input type="checkbox"/> 6x6		<input type="checkbox"/> Xeroform	<input type="checkbox"/> 4x4 <input type="checkbox"/> 5x9	
	<input type="checkbox"/> Biatain Silicone Border	<input type="checkbox"/> 3x3 <input type="checkbox"/> 4x4 <input type="checkbox"/> 5x5 <input type="checkbox"/> 6x6		<b>HYDROCOLLOID DRESSING</b>		<b>QTY</b>
	<input type="checkbox"/> Biatain Silicone Lite Border	<input type="checkbox"/> 3x3 <input type="checkbox"/> 4x4 <input type="checkbox"/> 5x5		<input type="checkbox"/> Duoderm CGF	<input type="checkbox"/> 4x4 <input type="checkbox"/> 6x6	
	<input type="checkbox"/> Bordered Foam	<input type="checkbox"/> 2x2 pad <input type="checkbox"/> 4x4 pad <input type="checkbox"/> 4x6 pad		<input type="checkbox"/> Duoderm Extra Thin CGF	<input type="checkbox"/> 4x4 <input type="checkbox"/> 6x6	
	<input type="checkbox"/> Hydrofera BLUE Ready	<input type="checkbox"/> 4x5 <input type="checkbox"/> 8x8		<input type="checkbox"/> Duoderm Signal CGF	<input type="checkbox"/> 4x4 <input type="checkbox"/> 5 1/2 x 5 1/2	
	<input type="checkbox"/> Mepilex Foam	<input type="checkbox"/> 4x4.8 <input type="checkbox"/> 4x8 <input type="checkbox"/> 6x6 <input type="checkbox"/> 8x8		<input type="checkbox"/> Hydrocolloids Thin	<input type="checkbox"/> 2x2 <input type="checkbox"/> 4x4 <input type="checkbox"/> 6x6	
	<input type="checkbox"/> Mepilex Border	<input type="checkbox"/> 3x3 <input type="checkbox"/> 4x4 <input type="checkbox"/> 6x6 <input type="checkbox"/> 6x8		<input type="checkbox"/> Hydrocolloids Thick	<input type="checkbox"/> 2x2 <input type="checkbox"/> 4x4 <input type="checkbox"/> 6x6	
	<input type="checkbox"/> Mepilex Lite	<input type="checkbox"/> 2x3 <input type="checkbox"/> 4x4 <input type="checkbox"/> 6x6 <input type="checkbox"/> 8x20		<b>RETENTION DRESSING</b>		<b>QTY</b>
	<input type="checkbox"/> Mepilex Lite w/Border	<input type="checkbox"/> 1.6x2 <input type="checkbox"/> 2x5 <input type="checkbox"/> 3x3 <input type="checkbox"/> 4x4		<input type="checkbox"/> Tubifast Stretch	<input type="checkbox"/> Red <input type="checkbox"/> Green <input type="checkbox"/> Blue <input type="checkbox"/> Yellow <input type="checkbox"/> Purple	
	<input type="checkbox"/> Mepilex Transfer	<input type="checkbox"/> 6x8 <input type="checkbox"/> 8x20		<input type="checkbox"/> Tubifast Gloves (Private Pay Only)	Size:	
	<input type="checkbox"/> Polymem	<input type="checkbox"/> 3x3 <input type="checkbox"/> 5x5 <input type="checkbox"/> 6.5x7		<input type="checkbox"/> Tubifast Socks (Private Pay Only)	One Size	
	<input type="checkbox"/> Polymem AG	4.25x4.25		<input type="checkbox"/> Spandage (sizes 1-11)	Size:	
	<input type="checkbox"/> Restore Foam Non Adhesive	<input type="checkbox"/> 4x4 <input type="checkbox"/> 6x8		<b>MISCELLANEOUS</b>		<b>QTY</b>
<input type="checkbox"/> Restore Foam Adhesive	<input type="checkbox"/> 4x4 <input type="checkbox"/> 6x6 <input type="checkbox"/> 6x8		Tape: <input type="checkbox"/> Paper Tape <input type="checkbox"/> Cloth Tape <input type="checkbox"/> Plastic Tape <input type="checkbox"/> 1" <input type="checkbox"/> 2"			
<input type="checkbox"/> Restore Foam Silver	<input type="checkbox"/> 4x4 <input type="checkbox"/> 6x8		<input type="checkbox"/> Medipore Tape <input type="checkbox"/> 2" <input type="checkbox"/> 4"			
<input type="checkbox"/> Restore Foam Advanced	<input type="checkbox"/> 2 1/2 x 2 1/2 <input type="checkbox"/> 4x4		<input type="checkbox"/> Hypafix Tape <input type="checkbox"/> 2" <input type="checkbox"/> 4"			
<input type="checkbox"/> Restore Foam Advanced w/border	<input type="checkbox"/> 4x4 <input type="checkbox"/> 6x8		<input type="checkbox"/> Mepitac <input type="checkbox"/> 3/4" x 118" <input type="checkbox"/> 1 1/2" x 59"			
<input type="checkbox"/> Restore Foam Advanced Lite	<input type="checkbox"/> 2 1/2 x 2 1/2 <input type="checkbox"/> 4x5 <input type="checkbox"/> 6x6 <input type="checkbox"/> 6x8		<input type="checkbox"/> 3M Silicone Tape (Private Pay Only) <input type="checkbox"/> 1" <input type="checkbox"/> 2"			
<input type="checkbox"/> Tielle B Lite	2 3/4 x 3 1/2 (1 1/2 x 2 pad)		Gloves: <input type="checkbox"/> Vinyl <input type="checkbox"/> Latex <input type="checkbox"/> SM <input type="checkbox"/> MED <input type="checkbox"/> LG			
<b>TRANSPARENT DRESSING</b>		<b>QTY</b>	<b>OTHER DRESSINGS</b>		<b>QTY</b>	
<input type="checkbox"/> Tegaderm	<input type="checkbox"/> 2.3x2.7 <input type="checkbox"/> 4x4 3/4 <input type="checkbox"/> 6x8 <input type="checkbox"/> 8x12					

<b>DOCTOR</b>	eDocs <input type="checkbox"/>	Physician <input type="checkbox"/>	NPI # _____	Address _____	Phone _____	Fax _____	Email _____
	<input type="checkbox"/>	<input type="checkbox"/>	# _____				
	<input type="checkbox"/>	<input type="checkbox"/>	# _____				

I certify that I am the physician identified on this form. I have reviewed the Physician's Written Order. Any statement on my letterhead attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed, and physician notes and other supporting documentation will be provided to McKesson Patient Care Solutions upon request. I understand any falsification, omission or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

**X** Physician Signature \_\_\_\_\_ (Signature and Date stamps are not acceptable.)  
 Physician Name \_\_\_\_\_  
**X** Date \_\_\_\_\_ (Signature and Date stamps are not acceptable.)

This fax message and any attachments may contain confidential information. If you are not the intended recipient and have received this message in error, please inform sender and delete the contents without copying, distributing or forwarding. By faxing this form you are acknowledging that the patient is aware that an McKesson Patient Care Solutions Representative may be contacting them for any additional information to process this order. Thank you.