PRESCRIPTION FORM

Please fax this completed form to 888-608-0520 or email mbpatientsupport@rxtalents.com
You may also find this blank form at MBPatientSupport.RxTalents.com
PLEASE COMPLETE BOTH SIDES

PATIENT INFORMATION

First Name ____________________ Last Name ______________________ Middle Initial ____________________
Date of Birth ____/____/________ Phone #_________________________ Male __ Female__

Prescription:

Desired therapy (please type or write selection)____________________________________

Keragel 5g   Keragel 20g   KeragelT 5g   KeragelT 20g   Keramatrix 5 x 5   Keramatrix 10 x 10

Directions:____
Quantity:___________________Refills:___________________
DAW:_________

Prescriber Signature:____ Date:________________________

PRESCRIBER INFORMATION

Prescriber's Name ________________________________ Facility Name ________________________
Prescriber DEA # ________________________________ TIN_____________________________
Prescriber NPI ________________________________ Office Contact Name________________________
Office Contact Email ________________________________ Fax ( ) ____
Address ________________________________ Phone ( ) ________________________
City ________________________________ State ____________ Zip________________

AUTHORIZATION

I acknowledge that I received authorization to release the patient's personal health information and other pertinent details on this form to Molecular Biologicals and its affiliates, partners, vendors and others ("Agents") for the purpose of providing patient support services. I further acknowledge and certify that this service is provided by Molecular Biologicals on behalf of all patients willing to participate and not in exchange for express or implied agreement or understanding that I would recommend, use, or prescribe Molecular Biologicals products or services for anyone and my action to prescribe these products was based completely on my determination of medical necessity. I understand that this information may be used by Molecular Biologicals and Agents to continually develop the program.

In the event the patient is provided free product, I acknowledge that it is not contingent upon purchases or obligations. I also acknowledge that there will not be any claim for reimbursement submitted to Medicare, Medicaid, or any insurance provider for medication received at no charge in association with this program or for related medical procedures and services. Free product should also never be sold, traded or distributed for sale. I will notify RxTalents immediately if these products are no longer necessary for this patient's continued treatment.

I authorize Molecular Biologicals and its Agents as my designated agent and on behalf of my patient, to forward the prescription and information contained in association, to the patient's insurer and Diamond Pharmacy.

The prescriber is to comply with any state-specific prescription requirements.

By signing below, I certify that I have read and understand the Authorization and information and agree to its terms. I understand that I may request a copy of this Authorization.

________________________________ ________________________________
Prescriber Signature Printed Name
Date_________

MOLECULAR BIOLOGICALS

RXTALENTS
Accelerate Your Innovation

PRESCRIPTION FORM

Patient Name ___________________ Date of Birth _______________

DIAGNOSIS / TREATMENT INFORMATION

Diagnosis:_________________________________ICD-10 CODE______________________
Diagnosis:_________________________________ICD-10 CODE______________________
Diagnosis:_________________________________ICD-10 CODE______________________
How long has the wound been unhealed?_______________ What is the size of the wound in cm2?______________
What treatments have been tried?
Product / Procedure:_________________Duration:__________Pt Compliance_______Date:______. Failed?____
Product / Procedure:_________________Duration:__________Pt Compliance_______Date:______. Failed?____
Product / Procedure:_________________Duration:__________Pt Compliance_______Date:______. Failed?____
Explanation / Comments:____
____
____
____
____
____
Does the wound involve tendons, muscle, joint capsule?___________Is bone exposed or sinus tracts?___________
Is the wound clean and free of necrotic debris or exudate?__________
Does the area have adequate circulation / oxygenation to support tissue growth / wound healing as evidenced by physical examination (eg, ankle brachial index of no less than 0.60, toe pressure >30mm Hg)?______________
Does the patient have Type 1 or Type 2 Diabetes?________________Is diabetes under management?__________
Is the patient a smoker?__________Has the patient attempted to discontinue tobacco use?___________

Appropriate therapy for the following has been provided:
Control of edema, venous hypertension, lymphedema?________
Control of any nidus of infection or colonization with bacterial or fungal elements?________
Elimination of underlying cellulitis, osteomyelitis, foreign body, or malignant process?_______
Appropriate debridement of necrotic tissue or foreign body (exposed bone or tendon)?_______
For diabetic foot ulcers, appropriate non-weight bearing or off-loading pressure?_________
For venous stasis ulcers, compression therapy provided with documented diligent use of multilayer dressings, compression stockings of >20mmHq, or pneumatic compression?__________
Provision of wound environment to promote healing (protection from trauma and contaminants, elimination of inciting or aggravating processes)?_______