

1 PATIENT INFORMATION

Patient's Name _____
Date of Birth _____ Male Female
Street Address _____ Apt# _____
City _____ State _____ Zip _____
Parent/Guardian (if applicable) _____
Home Phone _____ Work Phone _____
Cell Phone _____ Evening Phone _____
E-mail address _____
Insurance Company Name _____
Insurance Company Phone No. _____
Insured's Name _____
Relationship to Patient _____
Identification No. _____ Policy/Group No. _____
Prescription Card No Yes If Yes, Carrier _____
Policy No. _____ Group No. _____
Is patient eligible for Medicare? No Yes **Please attach front and back copy of patient's insurance cards, if available.**

2 PRESCRIBER INFORMATION

Prescriber's Name _____
Office Contact _____
Clinic / Hospital Affiliation _____
Street Address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____
NPI No. _____ License No. _____
DEA No. _____
Physician Medicaid UPIN No. _____
MD Specialty _____

To reach your team, call toll-free 1.888.608.9010.

**Please fax completed form to the OsteoArthritis team
1.888.302.1028.**



3 CLINICAL INFORMATION

Primary ICD-9 Code: _____

Current Weight _____ kg/lbs Date Recorded _____

EXPECTED DATE OF FIRST/NEXT INJECTION: _____ DATE OF LAST INJECTION (if applicable): _____

Agency nurse to visit home for injection: Yes No

Agency Name & Phone: _____

- Rx:**
- | | |
|---|---|
| <input type="checkbox"/> Euflexxa® (hyaluronic acid) | <input type="checkbox"/> Vial |
| <input type="checkbox"/> Hyalgan® (sodium hyaluronate) | <input type="checkbox"/> Pre-filled Syringe |
| <input type="checkbox"/> OrthoVisc® (hyaluronate sodium) | |
| <input type="checkbox"/> Supartz® (sodium hyaluronate) 2.5 mL | |
| <input type="checkbox"/> Synvisc® (hylan G-F 20) | |

SIG: Inject Dose: _____ ml

Route: Intra-Articular

Frequency: _____

Dispense Quantity: _____

Refills: _____

NKDA Known Drug Allergies: _____

Deliver product to: Office Patient's Home Clinic Clinic Location _____

If shipped to physician's office, physician accepts on behalf of patient for administration in office

By signing below, I certify that the above therapy is medically necessary.

Prescriber's Printed Name _____

Prescriber's Signature (sign below) _____ **Date** _____

Dispense as Written

Substitution Allowed

(Physician attests this is his/her legal signature. **NO STAMPS**)