

## 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)   |   |
| <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**)