



Orthopedic Prescription/Pharmacy Intake Form

Phone: 877-235-9798

Fax: 877-235-9807

Provider Rep: _____

Territory: _____

PATIENT INFORMATION

Date Needed: _____

 New to Therapy Therapy Continuation

Name: _____ M F Home Phone w/ Area Code: _____
 Address: _____ Work Phone w/ Area Code: _____
 City: _____ State: _____ ZIP Code: _____ Cell Phone w/ Area Code: _____
 Patient Weight _____ Height _____ DOB: _____ PCP Name: _____
 Allergies: _____ PCP Phone w/ Area Code: _____
 Treatment Setting: Patient's home Prescriber's office Walgreens-OptionCare ATC Email: _____

INSURANCE INFORMATION (Please include copy of front and back of insurance card if possible)

Primary Insurance:	_____	Secondary Insurance:	_____
Patient's ID #	_____	Patient's ID #	_____
Cardholder's Name (if not patient)	_____	Cardholder's Name (if not patient)	_____
Phone w/ Area Code:	_____	Phone w/ Area Code:	_____
Group #	_____	Group #	_____

CLINICAL CRITERIA **REQUIRED Please check all that apply**

ICD-9 and Condition 715.16 Osteoarthritis, localized, primary, lower leg 715.26 Osteoarthritis, localized, secondary, lower leg
 715.36 Osteoarthritis, localized, unspecified, lower leg 715.96 Osteoarthritis, unspecified, lower leg
 Other (explain): _____

Injection Site Bilateral Left knee Right knee

Clinical History Date of diagnosis _____ Years with disease _____
 Therapy start date _____ Therapy stop date _____
 Previous / current use of NSAIDs Previous / current use of intra-articular corticosteroids
 Length of injection series _____ (3-5 weeks) Frequency of injections per year _____
 Known allergies _____
 Clinical notes _____

PRESCRIPTION INFORMATION

Medication	Form	Strength	Qty	Directions/Freq	Dose	Refills
Euflexxa®	1 kit (3 syringes 2.0mL each)					
Halgan® (sodium hyaluronate)	1 syringe (20 mg/2.0 mL)					
Orthovisc® (hyaluronan)	1 syringe (30 mg/2.0 mL)					
Supartz® (sodium hyaluronate)	1 syringe (25 mg/2.5 mL)					
Synvisc® (hylan G-F 20)	1 kit (3 syringes 2.0mL each)					
Synvisc-One™ (hylan G-F 20)	1 kit (1 syringe 6.0mL)					

Practice Name: _____ Prescriber's Name: _____
 Contact Name: _____ State License # _____ DEA # _____
 Address: _____ NPI # _____ UPIN _____
 City: _____ State: _____ ZIP Code: _____ Phone w/ Area Code: _____ Fax w/ Area Code: _____

Substitution Permissible. In order for a brand name product to be dispensed, the prescriber must handwrite 'BRAND NECESSARY' or "BRAND MEDICALLY NECESSARY" in the space provided: _____

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature Required: _____ Date: _____

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Redisclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.

Drug names are the property of their respective owners.