reliance|rx℠
45 Earhart Drive, Suite 110, Amherst, NY 14221

INTRA-ARTICULAR INJECTIONS AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name	First Name	Today's Date	Date Needed
Parent/Guardian		Prescriber	Hospital/Clinic
Home Phone Number ( )	Work Phone Number ( )	Phone Number ( )	Fax Number ( )
Home Address	City State Zip	Address	City State Zip
Ship To	☐ Prescriber ☐ Patient's Home	Office Contact	Prescriber Speciality
Language Preference	☐ English ☐ Spanish ☐ Other		
Known Allergies:		Contact Preference ☐ Phone ☐ Fax ☐ Email _____	
Weight _____ lbs.	Height ____ ft. ___ in.	Date of Birth ____ /____ /____	Sex ☐ M ☐ F
		Special Instructions	

INSURANCE INFORMATION

Fill out entirely or fax a copy of patient's insurance card (both sides):

Primary Insurance: _____

Name of Insured: _____

Policy #: _____

Group #: _____

Phone #: _____

Rx Drug Card #: _____

Secondary Insurance: _____

Name of Insured: _____

Policy #: _____

Group #: _____

Phone #: _____

Rx Drug Card #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD9 Code: _____

Affected Knee(s): _____

Has patient tried and failed to respond to conservative non-pharmacologic therapy (exercise, physical therapy, weight loss) within the previous 18 months? ☐ Yes ☐ No

Has patient tried and failed to respond to simple analgesics (oral salicylates, non-steroidal anti-inflammatory drugs [NSAIDs], acetaminophen) within the previous 18 months? ☐ Yes ☐ No

Hx of medications tried and failed: _____

When was patient last on these therapies? _____

Was patient on Hyaluronate products? ☐ Yes ☐ No

If yes, when was the last injection? _____

INTRA-ARTICULAR INJECTIONS OF HYALURONATE PRODUCTS

Dose: _____

Frequency: _____

EUFLEXXA® 20mg/2ml
☐ 3 syringes ☐ 6 syringes (bilateral treatment)
Directions: ☐ Inject weekly as directed ☐ Other _____

If request is for a project other than Euflexxa, please check below and document why Euflexxa is not indicated for this patient:

Synvisc®
☐ 3 syringes ☐ 6 syringes (bilateral treatment)
Directions: ☐ Inject weekly as directed ☐ Other _____

Synvisc® – ONE
☐ 1 syringes ☐ 2 syringes (bilateral treatment)
Directions: ☐ Inject weekly as directed ☐ Other _____

Hylagan® 20mg/2ml
☐ 5 syringes ☐ 10 syringes (bilateral treatment)
Directions: ☐ Inject weekly as directed ☐ Other _____

Supartz® 20mg/2ml
☐ 5 syringes ☐ 10 syringes (bilateral treatment)
Directions: ☐ Inject weekly as directed ☐ Other _____

Orthovisc®
☐ 3 syringes ☐ 4 syringes (bilateral treatment)
Directions: ☐ Inject weekly as directed ☐ Other _____