US Bioservices
AmerisourceBergen Specialty Group

SYNVISC patient enrollment form

FAX: 1-866-908-2142
PHONE: 1-800-801-1140

PATIENT INFORMATION (please print clearly)

Last Name

First Name

Social Security No. Date of Birth

Guardian/Caregiver

Home Phone Work or Mobile Phone

Home Address

City, State, Zip

PATIENT INSURANCE INFORMATION

Medical Insurance (Fax Copy of Card) **Medical Insurance Phone**

Subscriber Name

Policy # Group #

Prescription Card (fax copy of card) **Prescription Card Phone**

Policy # BIN / PCN

Medicare Number **Medicaid Number**

PRESCRIBER INFORMATION

❍ MD ❍ DO ❍ NP ❍ PA

Prescriber Name (please print)

Prescriber Address

City, State, Zip Practice Name

Phone Fax

License # NPI # UPIN #

DEA # Supervising Physician (if applicable)

Office Contact Backline Phone Number

PRESCRIPTION

❍ **SYNVISC Syringe 2mL x 3 (16mg/2mL) of hylan G-F in 2.25mL glass syringe** Dispense________ Refills________

❍ Sig: Inject intra-articular once a week (one week apart) for a total of 3 injections
❍ Other: ____

❍ **SYNVISC One 1 dose (48mg/6mL) of hylan G-F in 10 mL glass syringe** Dispense________ Refills________

❍ Administer as a single intra-articular injection
❍ Other ____
Sig: ____

CLINICAL INFORMATION

Patient Weight _________ kg lbs (circle one) Allergies:___________________

- ❍ Osteoarthritis, localized, primary, lower leg (715.16)
- ❍ Osteoarthritis, localized, secondary, lower leg (715.26)
- ❍ Osteoarthritis, localized, not specified whether primary or secondary, lower leg (715.36)
- ❍ Osteoarthritis,unspecified, lower leg (715.96)
- ❍ Pain in joint, lower leg (719.46)
- ❍ Temporomandibular joint disorder, articular disc disorder (524.63)
- ❍ Other (ICD Required) Dx:_________________

Date First Injection Scheduled: ___________________
Injection Sites: ❍ Left Knee ❍ Right Knee ❍ Bilateral Knees ❍ Other:__________________________

PATIENT INFORMATION:

Does the individual have documented symptomatic osteoarthritis of the knee?	❍ Yes	❍ No
Does the individual report pain that interferes with functional activities (e.g., ambulation or prolonged standing)?	❍ Yes	❍ No
Has the patient tried conservative therapy (including oral medications) without improvement for at least three months?	❍ Yes	❍ No
Does the patient have any contraindications to viscosupplementation injections?	❍ Yes	❍ No

PATIENT HISTORY:

Drug Name	Dates	Duration

NURSING

Deliver to: ❍ Prescriber Office ❍ Other: ____

Prescriber Signature **Date**
No Stamps. Prescriber Signature required.

❍ Hold Shipment until notified by prescriber