Orthopedic Prescription/Pharmacy Intake Form

Walgreens Specialty Pharmacy

Phone: 866-202-4014 Fax: 866-493-2546

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 Osteoarthrosis, localized, primary, lower leg
- ☐ 715.26 Osteoarthrosis, localized, secondary, lower leg
- ☐ 715.36 Ostearthrosis, localized, unspecified, lower leg
- ☐ 715.96 Osteoarthrosis, 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: _____