



Orthopedic Prescription/Pharmacy Intake Form

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 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.

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Drug names are the property of their respective owners.