Ph: 877.227.3405 • Fax: 877.542.2731 • E-Prescribe NPI # 1659380772 or NCPDP # 3306986

Osteoarthritis Prescription Form

PATIENT INFORMATION You may also fax demographics/face sheet

Patient Name: ____________________ DOB: __________
SSN: ____________________
Address: ____________________
City, State, Zip: ____________________
Home Phone: __________ Cell Phone: __________
Known Allergies: ____________________
Height: __________ Weight: __________ lbs. ☐ M ☐ F
Emergency Contact: ____________________
Emergency Contact Phone: ____________________

INSURANCE INFO. Please fax copy of ALL insurance cards *front & back

Primary Insurance: ____________________
City, State: ____________________
ID Number: ____________________
Group Number: __________ Rx Bin: __________
Secondary Insurance: ____________________
City, State: ____________________
ID Number: ____________________
Group Number: __________ Rx Bin: __________

PRESCRIBER INFORMATION

Prescriber Name: ____________________ License: __________ DEA: __________
Address: ____________________ City, State, Zip: ____________________
Office Contact: ____________________ Phone: __________ Fax: __________

DIAGNOSIS INFORMATION Please fax recent labs, clinical notes, etc. to help expedite the prior authorization process

☐ Osteo Arthritis ☐ Other: ____________________

ICD-10:

☐ M17.0 Bilateral primary OA of knee
☐ M17.11 Unilateral primary OA, right knee
☐ M17.2 Bilateral post-traumatic OA of kneee
☐ M17.31 Unilateral post-traumatic OA, right knee
☐ M17.4 Other bilateral secondary OA of knee
☐ M17.9 OA of knee, unspecified
☐ M17.10 Unilateral primary OA, unspecified knee
☐ M17.12 Unilateral primary OA, left knee
☐ M17.30 Unilateral post-traumatic OA, unspecified knee
☐ M17.32 Unilateral post-traumatic OA, left knee
☐ M17.5 Other unilateral secondary OA of knee
☐ Other code: __________ Description: ____________________

Prior Failed Therapies: ____________________

Reason For Discontinuation: ____________________

MEDICATIONS: You may tape Prescriptions here prior to faxing

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
☐**Durolane®**	60 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		
☐**Euflexxa®**	20 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		
☐**Gel-One®**	30 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		
☐**Gelsyn-3®**	16.8 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		
☐**GenVisc 850®**	25 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for ________ weeks. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		
☐**Hyalgan®**	☐ 20 mg/2 mL prefilled syringe ☐ 20 mg/2 mL vial	Inject contents of prefilled syringe intra-articularly once a week for ________ weeks. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		
☐**Hymovis®**	24 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 2 weeks. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		

DELIVERY INFORMATION

Need by: ____________________ **Deliver to:** ☐ MD Office/ Clinic ☐ Other: ____________________

PRESCRIBER'S SIGNATURE REQUIRED

MD | NP | PA Signature: ____________________ ☐ **DAW** **Date:** __________

*Signature on this form also provides consent to contact this patient's insurance provider for this prescription on the provider's behalf.

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INSURANCE INFO. Please fax copy of ALL insurance cards *front & back

Primary Insurance: ______________________
City, State: ______________________
ID Number: ______________________
Group Number: ______________ Rx Bin: ______________
Secondary Insurance: ______________________
City, State: ______________________
ID Number: ______________________
Group Number: ______________ Rx Bin: ______________

PRESCRIBER INFORMATION

Prescriber Name: ______________________ License: ______________ DEA: ______________
Address: ______________________ City, State, Zip: ______________________
Office Contact: ______________________ Phone: ______________ Fax: ______________

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MEDICATIONS: You may tape Prescriptions here prior to faxing

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
☐Monovisc®	88 mg/4 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		
☐Orthovisc®	30 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for ________ weeks. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		
☐Supartz FX®	25 mg/2.5 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for ________ weeks. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		
☐Synvisc®	16 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		
☐Synvisc-One®	48 mg/6 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		
☐TriVisc®	25 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		
☐Visco-3™	25 mg/2.5 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use: ☐ Left knee ☐ Right knee ☐ unilaterally ☐ bilaterally		

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