



Osteoarthritis

Delivery Need By:		_ Deliver to:	Detient's Home	🗆 Physician's Office	□ Other		
P	ATIENT INFORMATI	ON	PRES	SCRIBER INFORM	ATION		
Patient Name: <pre></pre>			Office Contact Nam Address: City: Phone Number:	Prescriber's Name:			
INSURA	NCE - PLEASE F	AX COPY O	F PRESCRIPT	ION CARD FRO	ONT & BA	ACK	
		CLINICAL	INFORMATION				
Diagnosis:			Has the patient been treated previously for this condition?				
ICD-10 Code:				🗆 Yes 🛛 No			
	ft inches We		Medications Failed: Medications On: Other Notes:				
				Ν			
Medication:	Dosage/Stre			ections:	Quantity:	Refills:	
Duexis	🗆 800mg/26.6 mg tablet		□ Take 1 tablet by mou	ith time(s) a day	□ day supply		
Euflexxa	□ 20mg / 2 mL prefilled syrin	ige	□ Inject contents of pro articularly once a we Patient to use: □ Unite	ek for three weeks.	Prefilled Syringes		
Gel-One®	□ 30mg/3mL prefilled syring	e	□ Inject contents of pro articularly one time. Patient to use: □ Unilat		□ Prefilled Syringes		
Genvisc 850	□ 2.5 ml prefilled syringe		 Inject contents of pr articularly one time. Patient to use: Unilat 				
Hyalgan	□ 20 mg/2ml prefilled syring □ 20 mg/2ml vial	e	□ Inject contents of pro articularly once a we Patient to use: □ Unilat	eek for five weeks	□ Prefilled Syringes □ Vials		
Monovisc	□ 88mg/4ml prefilled syringe		 Inject contents of prefilled syringe intra- articularly one time. Patient to use: Unilaterally Bilaterally 		□ Prefilled Syringes		
Orthovisc	□ 30 mg/2ml prefilled syringe		□ Inject contents of prefilled syringe intra- articularly once a week for weeks. Patient to use: □ Unilaterally □ Bilaterally		□ Prefilled Syringes		
Pennsaid	□ 40mg/2% pump		onto knee or first into hand then onto knee. Pu		D Pumps		
□ Include one 20G 1.5" needle per syringe		 Patient is interested in patient support programs 			 Ancillary supplies provided for administration 		

Physician Signature: _____

Date:

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Osteoarthritis

Delivery Need By:			□ Patient's Home 🛛	□ Physician's Office	🗆 Other					
P	ATIENT INFORMATI	SCRIBER INFORM	ATION							
Address: City: Phone Numb Email Addres Last Four of So		□ Female _ Zip: 3: AX COPY C	Office Contact Name Address: City: Phone Number: DEA/NPI #:	State: Fax:	Zip:					
Diagnosis:			Has the patient been treated previously for this condition?							
ICD-10 Code: _			□ Yes □ No							
Height: ft inches Weight: lbs Allergies:			Medications Failed: Medications On: Other Notes:							
PRESCRIPTION INFORMATION										
Medication:	Dosage/Stren	gth:		ections:	Quantity:	Refills:				
Medication: Provisc Supartz	Dosage/Stren	-		ections: efilled syringe intra- eek for five weeks.	Quantity:	Refills:				
Provisc		ge	Dire Inject contents of pre articularly once a we	ections: efilled syringe intra- eek for five weeks. terally [] Bilaterally efilled syringe/ intra- eek for three weeks.	□ Prefilled	Refills:				
Provisc Supartz	□ 25 mg/2.5ml prefilled syrin	ge	Direct Inject contents of preaticularly once a we Patient to use: Unilat	ections: efilled syringe intra- eek for five weeks. terally \Box Bilaterally efilled syringe/ intra- eek for three weeks. terally \Box Bilaterally efilled syringe/ intra-	Prefilled Syringes	Refills:				
Provisc Supartz Synvisc	□ 25 mg/2.5ml prefilled syrin □ 16 mg/2.5ml prefilled syring	ge ge	Direct Inject contents of pre- articularly once a we Patient to use: Unilat Inject contents of pre- articularly once a we Patient to use: Unilat Inject contents of pre- articularly one time. Patient to use: Unilat	ections: efilled syringe intra- eek for five weeks. terally \Box Bilaterally efilled syringe/ intra- eek for three weeks. terally \Box Bilaterally efilled syringe/ intra-	Prefilled Syringes	Refills:				
Provisc Supartz Synvisc Synvisc One	□ 25 mg/2.5ml prefilled syrin □ 16 mg/2.5ml prefilled syring □ 48 mg/6 ML prefilled syring	ge ge	Direct Inject contents of pre- articularly once a we Patient to use: Unilat Inject contents of pre- articularly once a we Patient to use: Unilat Inject contents of pre- articularly one time. Patient to use: Unilat	ections: efilled syringe intra- eek for five weeks. terally Bilaterally efilled syringe/ intra- eek for three weeks. terally Bilaterally efilled syringe/ intra- terally Bilaterally	 Prefilled Syringes Prefilled Syringes Prefilled Syringes Aay 	Refills:				

Date:

Physician Signature: ____

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