Osteoarthritis

Delivery Need By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other_____

PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPI #: _____

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ inches Weight: _____ lbs

Allergies: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Duexis	☐ 800mg/26.6 mg tablet	☐ Take 1 tablet by mouth ___ time(s) a day	☐ ___ day supply	
Euflexxa	☐ 20mg / 2 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for three weeks. Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ _____ Prefilled Syringes	
Gel-One®	☐ 30mg/3mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly one time. Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ _____ Prefilled Syringes	
Genvisc 850	☐ 2.5 ml prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly one time. Patient to use: ☐ Unilaterally ☐ Bilaterally		
Hyalgan	☐ 20 mg/2ml prefilled syringe ☐ 20 mg/2ml vial	☐ Inject contents of prefilled syringe intra-articularly once a week for five weeks Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ _____ 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	☐ Dispense 40mg (2 pump actuations) directly onto knee or first into hand then onto knee.	☐ _____ Pumps	

☐ Include one 20G 1.5" needle per syringe ☐ Patient is interested in patient support programs ☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____

Osteoarthritis

Delivery Need By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other _____

PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
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CLINICAL INFORMATION

Diagnosis: _____

ICD-10 Code: _____

Height: _____ ft _____ inches Weight: _____ lbs

Allergies: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Provisc				
Supartz	☐ 25 mg/2.5ml prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for five weeks. Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ _____ Prefilled Syringes	
Synvisc	☐ 16 mg/2.5ml prefilled syringe	☐ Inject contents of prefilled syringe/ intra-articularly once a week for three weeks. Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ _____ Prefilled Syringes	
Synvisc One	☐ 48 mg/6 ML prefilled syringe	☐ Inject contents of prefilled syringe/ intra-articularly one time. Patient to use: ☐ Unilaterally ☐ Bilaterally	☐ _____ Prefilled Syringes	
Vimovo	☐ 375/20 500/20 delayed- release tablets	☐ Take one tablet by mouth ____ time(s) a day	☐ ___ day supply	
Other				

☐ Include one 20G 1.5" needle per syringe ☐ Patient is interested in patient support programs ☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____