

1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY:

Date of Diagnosis: _____ ICD-10: _____
 Select Diagnosis: Knee Hip Hand Other diagnosis
 Signs of abnormal synovial fluid? Yes No
 Erythrocyte sedimentation rate: _____
 Prior trial with or contraindication to intra-articular corticosteroid therapy? Yes No
 Does patient have any contraindication to requested therapy?
 Yes No
 Is patient scheduled for knee replacement within the next 6 months?
 Yes No
 Is the patient allergic to any avian proteins, feathers, or eggs
 Yes No

Prior Failed Treatments:

- Non-Pharmacologic:**
- Strength Training
 - Physical Therapy
 - Assisted Walking Devices
 - Diet Changes
 - Weight Loss

Pharmacologic:

- NSAID (Ibuprofen)
- Acetaminophen (Tylenol)
- Capsaicin (Topical Cream)
- Topical Creams (Hydrocortisone)
- Other: _____

Indicate Drug Name and Length of Treatment

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 PRODUCT DELIVERY: MD Authorized Patient Pick Up Or Delivery Physician's Office

5 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> DUROLANE®	<input type="checkbox"/> 60 mg/3 mL prefilled syringe	<input type="checkbox"/> Inject 60 mg intra-articularly once weekly for 2 weeks	1 Syringe per carton	0
<input type="checkbox"/> MONOVISC®	<input type="checkbox"/> 88 mg/4 mL prefilled syringe	<input type="checkbox"/> Inject 88 mg intra-articularly as a one-time dose	1 Syringe per carton	0
<input type="checkbox"/> ORTHOVISC®	<input type="checkbox"/> 30 mg/2 mL prefilled syringe	<input type="checkbox"/> Inject 30 mg intra-articularly once weekly for 3-4 weeks	1 Syringe per carton	0
<input type="checkbox"/> SUPARTZ FX®	<input type="checkbox"/> 25 mg/ 2.5 mL prefilled syringe	<input type="checkbox"/> Inject 25 mg intra-articularly once weekly for 5 weeks	1 Syringe per carton	0
<input type="checkbox"/> SYNVISCO-ONE®	<input type="checkbox"/> 48 mg/6 mL prefilled syringe	<input type="checkbox"/> Inject 48 mg intra-articularly as a one-time dose	1 Syringe per carton	0
<input type="checkbox"/> ZILRETTA®	<input type="checkbox"/> 32mg/5 mL prefilled syringe	<input type="checkbox"/> Inject 32 mg intra-articularly as a one-time dose	1 Syringe per Kit	0
<input type="checkbox"/> OTHER	_____	_____		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.