



# OSTEOARTHRITIS ENROLLMENT/PRESCRIPTION FORM

**Customer Service Phone 1-800-850-9122**  
**Fax 1-800-218-3221**

## PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address	City, State	Zip	Date of Birth / /
Shipping Address (if different from home address)	Ship to MD	Home Phone Number ( )	Work Phone Number ( )

## INSURANCE INFORMATION

(fill out entirely or fax a copy of patient's Insurance card, both sides)

<b>Primary Insurance</b>	<b>Secondary Insurance</b>
Policy Number	Policy Number
Group Number	Group Number

## MEDICAL INFORMATION

Diagnosis: Osteoarthritis    Other (specify): \_\_\_\_\_

Start Date of Therapy: \_\_\_\_\_    End Date of Therapy: \_\_\_\_\_    Initiation of Therapy    Continuation of Therapy

Height: \_\_\_\_\_ Cm    In    Weight: \_\_\_\_\_ Lbs.    Kg    Date Measurement: \_\_\_\_\_    See Attached

Notes: \_\_\_\_\_

Allergies: \_\_\_\_\_     PKDA

Current Medications: \_\_\_\_\_     See Attached

Previous Treatment with: \_\_\_\_\_     See Attached

Reason for Discontinuation: \_\_\_\_\_     See Attached

## PRESCRIPTION INFORMATION

<b>Euflexxa 2ml Syringe</b>	<b>Hyalgan 2ml Syringe</b>
Right Knee    Left Knee    Both Knees	Right Knee    Left Knee    Both Knees
2ml IA every week for _____ weeks	2ml IA every week for _____ weeks
Qty _____ Refill x _____	Qty _____ Refill x _____
<b>Orthovisc 2ml Syringe</b>	<b>Supartz 2.5ml Syringe</b>
Right Knee    Left Knee    Both Knees	Right Knee    Left Knee    Both Knees
2ml IA every week for _____ weeks	2.5ml IA every week for _____ weeks
Qty _____ Refill x _____	Qty _____ Refill x _____
<b>Synvisc 2ml Syringe</b>	<b>Synvisc-One 6ml Syringe</b>
Right Knee    Left Knee    Both Knees	Right Knee    Left Knee    Both Knees
2ml IA every week for _____ weeks	6ml IA once
Qty _____ Refill x _____	Qty _____ Refill x _____

## PRESCRIBER INFORMATION

Prescriber Name	Specialty	Office Contact	Phone Number ( )
Address	City, State	Zip	Fax Number ( )
Today's Date	Date Needed By	DEA    On File	NPI    On File

I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.

Prescriber's Signature \_\_\_\_\_

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist. For refills, please call-in or fax 7 days in advance of next appointment.

**CONFIDENTIALITY STATEMENT:** This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.    V.08.11