

**PATIENT INFORMATION**

Last Name	First Name	MI	ID Number
Home Address	City	State	Zip
Date of Birth / /		Shipping Address (if different from home address) <input type="checkbox"/> 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

Weight: \_\_\_\_\_  lbs  kg Height: \_\_\_\_\_  in  cm Date of Measurement: \_\_\_\_\_  See Attached

Allergies: \_\_\_\_\_  NKDA

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

Co-Morbidities: \_\_\_\_\_  See Attached

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

**PRESCRIPTION INFORMATION**

<input type="checkbox"/> <b>Euflexxa 2ml Syringe</b>	<input type="checkbox"/> <b>Hyalgan 2ml Syringe</b>
<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees
<input type="checkbox"/> 2ml IA every week for 3 weeks	<input type="checkbox"/> 2ml IA every week for _____ weeks
Quantity: _____ Refill x: _____	Quantity: _____ Refill x: _____
<input type="checkbox"/> <b>Orthovisc 2ml Syringe</b>	<input type="checkbox"/> <b>Supartz 2.5ml Syringe</b>
<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees
<input type="checkbox"/> 2ml IA every week for _____ weeks	<input type="checkbox"/> 2.5ml IA every week for _____ weeks
Quantity: _____ Refill x: _____	Quantity: _____ Refill x: _____
<input type="checkbox"/> <b>Synvisc 2ml Syringe</b>	<input type="checkbox"/> <b>Synvisc-One 6ml Syringe</b>
<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees
<input type="checkbox"/> 2ml IA every week for _____ weeks	<input type="checkbox"/> 6ml IA once
Quantity: _____ Refill x: _____	Quantity: _____ Refill x: _____

**PRESCRIBER INFORMATION**

Prescriber Name	Specialty	Office Contact	Phone Number
Address	City	State	Zip
			Fax Number
Today's Date / /	Date Needed By / /	DEA <input type="checkbox"/> On File	NPI <input type="checkbox"/> 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.

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