

ORTHOPEDIC REFERRAL FORM

PATIENT INFORMATION

(Complete the following or send patient's demographic sheet)

Last Name _____ First Name _____ Sex M F _____ Date of Birth _____

Address _____ Home Phone _____ Work/Mobile Phone _____

Medicare # _____ Medical # _____ Other _____ Facility _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-10 code): M15.0 Osteoarthritis M15.9 Polyosteoarthritis unspecified

- Is Patient using prescribed therapy in combination with other biologics for MS? Yes No
- Is Patient pregnant, nursing, or planning pregnancy? Yes No N/A | Allergies: _____

INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (Front and Back)

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
<input type="checkbox"/> HYALGAN	<input type="checkbox"/> 20mg/2ml Syringe <input type="checkbox"/> 20mg/2ml Vial	_____	_____	_____
<input type="checkbox"/> MONOVISC	<input type="checkbox"/> 88mg/4ml Syringe	_____	_____	_____
<input type="checkbox"/> ORTHOVISC	<input type="checkbox"/> 15mg/ml Syringe	_____	_____	_____
<input type="checkbox"/> SUPARTZ	<input type="checkbox"/> 25mg/2.5ml Syringe	_____	_____	_____
<input type="checkbox"/> EUFLEXXA	<input type="checkbox"/> 20mg/2ml	_____	_____	_____
<input type="checkbox"/> SYNVISIC ONE	<input type="checkbox"/> 48mg/6ml <input type="checkbox"/> 16mg/2ml	_____	_____	_____

Prescriber Certification: I certify the above therapy is medically necessary and that the information above is accurate to the best of my knowledge

Physician Signature: _____ Date: _____ Office contact: _____

Physician Name: _____ UPIN # _____ NPI # _____ DEA# _____

Physician Address: _____ Phone # _____ Fax # _____

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