

PATIENT INFORMATION

Patient Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Allergies		<input type="checkbox"/> NKDA
Date of Birth		SSN#	Weight _____	<input type="checkbox"/> kg <input type="checkbox"/> lb	Date
Address		City	State	Zip	
Phone # (Home)	(Work)	Email address(optional)			

INSURANCE INFORMATION (PLEASE ATTACH A PHOTOCOPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS)

Primary Insurance		Medicare ID
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

DIAGNOSIS/MEDICAL INFORMATION (PLEASE SPECIFY PRIMARY AND SECONDARY DIAGNOSES)

715.0 Osteoarthritis (OA) Which knee is being treated? Left Right Both Other ICD 9

PRESCRIPTION INFORMATION

Medication	Dose	Directions/Frequency of Administration	Total # Doses
<input type="checkbox"/> Euflexxa® (Sodium Hyaluronate)	20 mg/2 ml	Inject 20 mg intra-articularly once weekly <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> bilateral	<input type="checkbox"/> ___ syringes <input type="checkbox"/> 3 syringes <input type="checkbox"/> 6 syringes (bilateral only)
<input type="checkbox"/> Hyalgan® (Sodium Hyaluronate)	20 mg/2 ml	Inject 20 mg intra-articularly once weekly <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> bilateral	<input type="checkbox"/> ___ syringes <input type="checkbox"/> 3 syringes <input type="checkbox"/> 5 syringes <input type="checkbox"/> 6 syringes (bilateral only) <input type="checkbox"/> 10 syringes (bilateral only)
<input type="checkbox"/> Othovisc® (Sodium Hyaluronate)	30mg/2ml	Inject 30 mg intra-articularly once weekly <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> bilateral	<input type="checkbox"/> ___ syringes <input type="checkbox"/> 3 syringes <input type="checkbox"/> 6 syringes (bilateral only)
<input type="checkbox"/> Supartz® (Sodium Hyaluronate)	25 mg/2.5 ml (5 syringes/kit)	Inject 25 mg intra-articularly once weekly <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> bilateral	<input type="checkbox"/> ___ syringes <input type="checkbox"/> 1 kit <input type="checkbox"/> 2 kits (bilateral only)
<input type="checkbox"/> Synvisc® (Hylan G-F 20)	16 mg/2 ml (3 syringes/kit)	Inject 16 mg intra-articularly once weekly <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> bilateral	<input type="checkbox"/> ___ syringes <input type="checkbox"/> 1 kit <input type="checkbox"/> 2 kits (bilateral only)
<input type="checkbox"/> Other:			

DELIVERY INSTRUCTIONS

Order will be shipped to the address provided below. Physician must be registered with CAP at this location and this must be the site of administration.	Administration Date *
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PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address	City/State/Zip	
DEA #	UPIN #	
CAP PIN #	NPI #	

Physician's Signature _____ **Date** _____
(required to process prescription – stamped signatures are not permissible)