

FAX FORM TO: 1.877.597.3070

PHONE: 1.800.473.3516

EMAIL: specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION		2. PRESCRIBER INFORMATION	
Name:		Name:	
Address:		DEA #:	NPI #: State Lic. #:
City, State, ZIP:		Group or Hospital:	
Primary Phone: - -	DOB: / /	Address:	
Alternate Phone: - -	Gender:	City, State, Zip:	
Email:		Phone: - -	Fax: - -
Primary Language:	Last Four of SSN:	Contact Person: Phone: - -	

3. INSURANCE INFORMATION *Fax copy of prescription and insurance cards with this form, if available (front and back)*

Primary Insurance Company Name:	Secondary Insurance Company Name:
Primary Cardholder Name:	Secondary Cardholder Name:
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent
Phone: - - Member ID: Group #:	Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / /	Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:
Date of Diagnosis: / /	Has patient received injection training? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> M15.0 Primary (osteo)arthritis <input type="radio"/> Other:	Specialty pharmacy to coordinate home health nursing visit as necessary: <input type="radio"/> Yes <input type="radio"/> No
Height (in/cm): Weight (lb/kg):	Agency of choice: <input type="radio"/> Home health nursing coordination is not necessary
Allergies:	Reason: <input type="radio"/> MD office administered <input type="radio"/> Home health nursing already coordinated
Current Medications:	

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="radio"/> Euflexxa	<input type="radio"/> 20 mg/2 ml PFS	<input type="radio"/> Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. <input type="radio"/> Other:		
<input type="radio"/> Gel-One	<input type="radio"/> 30 mg/3 ml PFS	<input type="radio"/> Inject contents of prefilled syringe intra-articularly one time. <input type="radio"/> Other:	1	0
<input type="radio"/> GELSYN-3	<input type="radio"/> 16.8mg/2ml PFS	<input type="radio"/> Inject contents of prefilled syringe intra-articularly once a week for 3 weeks		
<input type="radio"/> Hyalgan	<input type="radio"/> 20 mg/2 ml PFS <input type="radio"/> 20 mg/2ml vial	<input type="radio"/> Inject contents of vial/prefilled syringe intra-articularly once a week for ____ weeks. <input type="radio"/> Other:		
<input type="radio"/> Monovisc	<input type="radio"/> 88mg/4ml PFS	<input type="radio"/> Inject the contents of prefilled syringe intra-articularly one time		
<input type="radio"/> Orthovisc	<input type="radio"/> 30 mg/2 ml syringe	<input type="radio"/> Inject contents of vial/prefilled syringe intra-articularly once a week for ____ weeks. <input type="radio"/> Other:		
<input type="radio"/> Supartz FX	<input type="radio"/> 25 mg/2.5 ml PFS	<input type="radio"/> Inject contents of prefilled syringe intra-articularly once a week for 5 weeks. <input type="radio"/> Other:		
<input type="radio"/> Synvisc	<input type="radio"/> 16 mg/2 ml PFS	<input type="radio"/> Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. <input type="radio"/> Other:		
<input type="radio"/> Synvisc One	<input type="radio"/> 48 mg/6 ml PFS	<input type="radio"/> Inject contents of prefilled syringe intra-articularly one time. <input type="radio"/> Other:	1	0

Include one 23G (for Supartz) or 20G (for all other listed drugs) 15* needle per syringe

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X	/ /	X	/ /
DISPENSE AS WRITTEN	DATE	PRODUCT SUBSTITUTION PERMITTED	DATE

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address or telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.