

Patient Information				Prescriber Information	
Patient Name:		DOB:		Prescriber's Name:	
Address:				NPI#:	
City:	State:	Zip:		DEA#:	License#:
Phone:		Alternate Phone:		SSN:	
Height:	Weight:	Allergies:		Phone:	Fax:
Emergency Contact:		Phone:		Contact Person:	
Is the patient pregnant, planning a pregnancy or nursing:				Yes	No
				Does the patient need interpreter services:	
				Yes	No

Documentation (Required)

Insurance Card (front and back) Current Medications History/Progress Notes

Clinical Assessment: Please fax recent clinical notes, labs and tests to expedite the Prior Authorization Process

 ICD-10 Codes: M19.0 Primary osteoarthritis of other joints
 Other ICD-10 Code(s): _____ (please specify)

Specific Labs Needed (note: send ALL labs, must include specific labs listed here)

Other: _____

Medication	Dose/Strength	Directions for Use	Qty	Refills
EUFLEXXA®	20mg/2ml prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks Other		
GEL-ONE®	0.3mg Prefilled Syringe	Inject contents of prefilled syringe intra-articularly one time Other		
HYALGAN®	20mg/2ml prefilled syringe	Inject contents of prefilled syringe/vial intra-articularly ones a week for ____ weeks Other		
ORTHOVISC®	30mg/2ml prefilled syringe Other	Inject contents of prefilled syringe/vial intra-articularly once a week for ____ weeks Other		
SUPARTZ®	25mg/2.5 ml prefilled syringe Other	Inject contents of prefilled syringe/vial intra-articularly once a week for ____ weeks Other		
SYNVISCO ONE®	48 mg/6ml prefilled syringe	Inject contents of prefilled syringe intra-articularly 1 one time Other		
SYNVISCO®	16mg/2ml prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks Other		

By signing this form I authorize Aleracare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature

Date