



FAX REFERRAL TO: 1-888-801-0404
PHONE: 1-888-570-9077

ORTHOPEDIC ENROLLMENT FORM

Date: _____ • Ship to: Patient Office
 Needs by Date: _____

PATIENT INFORMATION

(Complete the following *or send patient demographic sheet*)

Name: _____
 Address _____
 City, State, Zip: _____
 Cell Phone: _____
 Home Phone: _____
 SS#: _____
 Date of Birth: _____

Prescriber Information

Prescriber Name: _____
 DEA #: _____ NPI #: _____
 Group/Hospital: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax _____
 Contact Person: _____

INSURANCE INFORMATION

Primary Insurance/Prescription Card:
 PLEASE FAX COPY OF INS CARD (front and back if available)
Secondary Insurance/Prescription Card:
 PLEASE FAX COPY OF INS CARD (front and back if available)

DIAGNOSIS / ICD 10 CODE

<input type="checkbox"/> M17.0 Bilateral Osteoarthritis of the knee	<input type="checkbox"/>
<input type="checkbox"/> M17.11 Unilateral primary Osteoarthritis RIGHT knee	<input type="checkbox"/>
<input type="checkbox"/> M17.12 Unilateral primary Osteoarthritis LEFT knee	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	<input type="checkbox"/>

PRIOR FAILED MEDICATIONS/CONCOMITANT DISEASES

(PLEASE LIST)

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Workers Comp Information

Case # _____ Carrier: _____
 Employer: _____
 Name of Adjuster: _____ Ph# _____
 Date of accident: _____

PRESCRIPTION INFORMATION

MEDICATION		FREQUENCY/DIRECTIONS FOR USE	QUANTITY	REFI
<input type="checkbox"/> Synvisc One®	<input type="checkbox"/> Synvisc One	<input type="checkbox"/> 48mg Intra-Articularly once <input type="checkbox"/> Other:	<input type="checkbox"/> R knee <input type="checkbox"/> L knee <input type="checkbox"/> Both Knees	
<input type="checkbox"/> Synvisc®	<input type="checkbox"/> Synvisc 3 pack	<input type="checkbox"/> 16mg Intra-Articularly once weekly for 3 weeks <input type="checkbox"/> Other:	<input type="checkbox"/> R knee <input type="checkbox"/> L knee <input type="checkbox"/> Both Knees	
<input type="checkbox"/> Supartz FX®	<input type="checkbox"/> Supartz Pfs	<input type="checkbox"/> 25mg once per week for 5 injections <input type="checkbox"/> 25mg once per week for 3 injections	<input type="checkbox"/> R knee <input type="checkbox"/> L knee <input type="checkbox"/> Both Knees	
<input type="checkbox"/> Gel-One®	<input type="checkbox"/> 3 ml injection	<input type="checkbox"/> Inject 3ml at once	<input type="checkbox"/> R knee <input type="checkbox"/> L knee <input type="checkbox"/> Both Knees	
<input type="checkbox"/> Euflexxa®	<input type="checkbox"/> 20 mg pfs	<input type="checkbox"/> 20mg Intra-Articularly once weekly for 3 weeks	<input type="checkbox"/> R knee <input type="checkbox"/> L knee <input type="checkbox"/> Both Knees	
<input type="checkbox"/> Monovisc®	<input type="checkbox"/> 4 ml injection	<input type="checkbox"/> Inject 4ml at once	<input type="checkbox"/> R knee <input type="checkbox"/> L knee <input type="checkbox"/> Both Knees	
<input type="checkbox"/> Orthovisc®	<input type="checkbox"/> 3 ml pfs	<input type="checkbox"/> One syringe Intra-Articularly once weekly for 3 weeks <input type="checkbox"/> Other:	<input type="checkbox"/> R knee <input type="checkbox"/> L knee <input type="checkbox"/> Both Knees	
<input type="checkbox"/> Gelsyn-3™	<input type="checkbox"/> 3 x 2ml syringes	<input type="checkbox"/> One syringe Intra-Articularly once weekly for 3 weeks	<input type="checkbox"/> R knee <input type="checkbox"/> L knee <input type="checkbox"/> Both Knees	

 Prescriber Signature and Date

I authorize Focus Rx staff or its representatives to act as an agent of prescriber to execute any prior authorization or appeal on my behalf.