FocusRx
Positive Patient Outcomes

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

- ☐ M17.0 Bilateral Osteoarthritis of the knee
- ☐ M17.11 Unilateral primary Osteoarthritis RIGHT knee
- ☐ M17.12 Unilateral primary Osteoarthritis LEFT knee
- ☐ Other:

☐ _____
☐ _____
☐ _____
☐ _____

PRIOR FAILED MEDICATIONS/CONCOMMITANT DISEASES

(PLEASE LIST)

☐	☐
☐	☐

Workers Comp Information

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

PRESCRIPTION INFORMATION

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