For assistance, contact your pharmacy representative: _____ Phone: _____ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from prescriber's office or hospital **(may not be faxed by patient)**.

Walgreens | allianceRx Walgreens + PRIME

Orthopedic

Prescription/Pharmacy Intake Form

☐Central Pharmacy: _____

☐Retail/Community Pharmacy Fax: _____ Pharmacy Phone: _____

Date Needed: _____ **Treatment Setting:** ☐Patient's home ☐Prescriber's office ☐Walgreens

PATIENT INFORMATION

Patient name: _____ DOB: _____ ☐Male ☐Female

Address: _____

City: _____ State: _____ Zip code: _____

Phone # (Daytime): _____ Phone # (Evening): _____

E-mail Address: _____

Primary insurance **(Please include copy of front and back of card)**: _____

ID #: _____ Policy/Group #: _____ Phone #: _____ ☐Patient is eligible for Medicare

Name of Insured: _____ Employer: _____

Relationship to Patient: ☐Self ☐Other: _____ Prescription Card: ☐Yes ☐No Carrier: _____ Policy/Group #: _____

Secondary insurance **(Please include copy of front and back of card)**: _____

ID #: _____ Policy/Group #: _____ Phone #: _____ ☐Patient is eligible for Medicare

Name of Insured: _____ Employer: _____

Relationship to Patient: ☐Self ☐Other: _____ Prescription Card: ☐Yes ☐No Carrier: _____ Policy/Group #: _____

CLINICAL ASSESSMENT

☐Patient is new to therapy ☐Therapy continuation Diagnosis Code (ICD-10): _____

Injection Site ☐Bilateral ☐Left Knee ☐Right Knee

Clinical History

Date of Diagnosis _____ Years with Disease _____

Injection Date _____ Therapy Stop Date _____

☐Previous/Current Use of NSAIDs ☐Previous/Current Use of Intra-articular Corticosteroids

Length of injection series _____ week(s) Frequency of injections per year _____

Clinical Notes _____

Allergies: _____

Medication	Form	Strength	Quantity	Directions/Frequency	Dose	Refills
☐**Durolane** (sodium hyaluronate)	Pre-filled syringe	60 mg/3 mL				
☐**Euflexxa** (sodium hyaluronate)	1 kit (3 syringes 2.0 mL each)	20 mg/2 mL				
☐**Gel-One** (cross-linked hyaluronate)	Pre-filled syringe	30 mg/3 mL				
☐**Gelsyn-3** (sodium hyaluronate)	Pre-filled syringe	16.8 mg/2 mL				
☐**Genvisc 850** (sodium hyaluronate)	Pre-filled syringe	25 mg/2.5 mL				
☐**Hyalgan** (sodium hyaluronate)	Pre-filled syringe	20 mg/2 mL				
☐**Monovisc** (sodium hyaluronate)	Pre-filled syringe	88 mg/4 mL				
☐**Orthovisc** (sodium hyaluronate)	Pre-filled syringe	30 mg/2 mL				
☐**Supartz FX** (sodium hyaluronate)	Pre-filled syringe	25 mg/2.5 mL				
☐**Synvisc** (hylan G-F 20)	1 kit (3 syringes 2.0 mL each)	16 mg/2 mL				
☐**Synvisc-One** (hylan G-F 20)	Pre-filled syringe	48 mg/6 mL				
☐**Other:**						

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____

Address: _____ City: _____ State: _____ Zip code: _____

Office contact: _____ Phone: _____ Fax: _____

Email: _____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature.
I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ Dispense as written

_____ Substitution permitted

_____ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.