ASP CARES

Osteoarthritis

Ph: (214) 919-2090 or (877) 753-6878
Fax: 1 (888) 294-9434

MAIN POINT OF CONTACT
Name:_____
Phone:_____

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____
Home Address:_____ City:_____ State:_____ Zip Code:_____
DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____lbs.
Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:_____ Secondary Insurance:_____
ID#:_____ RxBin:_____ ID#:_____ RxBin:_____
RxGroup:_____ Pcn:_____ RxGroup:_____ Pcn:_____

PATIENT EVALUATION:

Does patient have a complete collapse of the joint space or bone loss? ☐ Yes ☐ No
Does patient have skin diseases or infection in or around the affected joint? ☐ Yes ☐ No
If patient has tried simple analgesics, please name and include strength and duration:_____
Has patient received previous course of treatment with dyaluronidase? ☐ Yes ☐ No
If Yes, how long ago? _____months
Did patient experience pain relief? ☐ Yes ☐ No
Does patient have extensive inflammation with joint effusion or an inflammatory flare? ☐ Yes ☐ No
Has patient been treated with simple analgesics in the past? ☐ Yes ☐ No
Unilateral or bilateral treatment? ☐ Unilateral ☐ Bilateral
Patient Weight: _____ ☐ kg ☐ lbs
Concomitant Medications:_____
Allergies:_____

MEDICATION INFORMATION:

Medication	Strength	Directions	Qty.	Refills
☐ Orthovisc ☐ Include one 20G 1.5" needle per syringe	☐ 30mg/2ml Syringe	Inject contents of prefilled syringe intra-articulary once a week for _____weeks		
☐ Mono Visc ☐ Include one 20G 1.5" needle per syringe/vial	☐ 88mg/4ml	Inject contents of prefilled syringe intra-articularly one time		
☐ Euflexxa ☐ Include one 20G 1.5" needle per syringe	☐ 20mg/2ml Prefilled Syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks		
☐ Supartz ☐ Include one 23G 1.5" needle per syringe	☐ 25mg/2.5ml Prefilled Syringe	Inject contents of prefilled syringe intra-articularly once a week for 5 weeks		
☐ Synvisc One ☐ Include one 20G 1.5" needle per syringe	☐ 48mg/6ml Prefilled Syringe	Inject contents of prefilled syringe intra-articularly one time		
☐ Synvisc ☐ Include one 20G 1.5" needle per syringe	☐ 16mg/2ml Prefilled Syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks		

℞

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____
Address:_____ City:_____ State:____ Zip Code:_____
Phone:_____ Fax:_____

***Prescriber Signature:_____Date:_____**

Please fax completed form to 1 (888) 294-9434