Orthopaedics Referral Form

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Zeal Specialty Pharmacy

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

ORTHOD23-01

PATIENT INFORMATION

Last Name	First Name	Date of Birth ____ /____ / ____	Gender ☐ Male ☐ Female
Address	City	State	Zip
email	Home Phone	Work Phone	Cell Phone

PRESCRIBER INFORMATION

Prescriber Full Name		Prescriber Credential	
Practice Address	City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – *please include any relevant office visit/lab notes*

Patient New to Therapy ☐ Naïve / New Start ☐ Therapy Restart ☐ Existing Treatment | Therapy Start Date ____ /____ / ____

Height _____ in Weight _____ lb Date ____ /____ / ____ | Allergies ☐ NKDA ☐ Drug Allergies (please list)

Therapies Tried and Failed (please list name and dose)

Concomitant Medications (please list name and dose)

ICD-10 Code
☐ M45.9 Ankylosing Spondylitis
☐ M17.10 OA-Knee
☐ M17.11 Unilateral primary osteoarthritis, right knee
☐ M17.12 Unilateral primary osteoarthritis, left knee
☐ Other

PRESCRIPTION – *please check all boxes across row*

Medication	Dose/Strength	Directions	Quantity
☐ **Durolane®**	20 mg/mL	Inject 60 mg (3 mL) once	☐ 1 syringe ☐ 2 syringes (bilateral only)
☐ **Euflexxa®**	20 mg/mL	Inject 20 mg intra-articularly once weekly	☐ 3 syringes ☐ 6 syringes (bilateral only)
☐ **Gelsyn®**	16.8 mg/ 2 mL	Inject 16.8 mg (2 mL) once weekly for 3 weeks (total of 3 injections)	☐ 3 syringes ☐ 6 syringes (bilateral only)
☐ **Hyalgan®**	20 mg/ 2 mL	Inject 20 mg intra-articularly once weekly	☐ 3 syringes ☐ 5 syringes ☐ 6 syringes (bilateral only) ☐ 10 syringes (bilateral only)
☐ **Monovisc®**	88 mg/ 4 mL	Inject 88 mg intra-articularly one time	☐ 1 syringe ☐ 2 syringes (bilateral only)
☐ **Orthovisc®**	30 mg/ 2 mL	Inject 30 mg intra-articularly once weekly	☐ ____ syringes
☐ **Supartz®**	25 mg/ 2.5 mL	Inject 25 mg intra-articularly once weekly	☐ 3 syringes ☐ 5 syringes ☐ 6 syringes (bilateral only) ☐ 10 syringes (bilateral only)
☐ **Synvisc®**	16 mg/ 2 mL	Inject 16 mg intra-articularly once weekly	☐ 3 syringes ☐ 6 syringes (bilateral only)
☐ **Synvisc-One®**	48 mg/ 6mL	Inject 48 mg intra-articularly one time	☐ 1 syringe ☐ 2 syringes (bilateral only)

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA. ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.*

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic | Date Shipment Needed By: ____ /____ / ____