

FAX FORM TO: 1.866.233.8317

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Complete the following or include demographic sheet.

1. PATIENT INFORMATION		2. PRESCRIBER INFORMATION	
Name: _____		Name: _____	
Address: _____		DEA #: _____	NPI #: _____ State Lic. #: _____
City, State, ZIP: _____		Group or Hospital: _____	
Primary Phone: - - - - -	DOB: / /	Address: _____	
Alternate Phone: - - - - -	Gender: _____	City, State, Zip: _____	
Email: _____		Phone: - - - - -	Fax: - - - - -
Primary Language: _____	Last Four of SSN: _____	Contact Person: _____ Phone: - - - - -	

**3. INSURANCE INFORMATION** *Fax copy of prescription and insurance cards with this form, if available (front and back)*

Primary Insurance Company Name: _____	Secondary Insurance Company Name: _____
Primary Cardholder Name: _____	Secondary Cardholder Name: _____
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent
Phone: - - - - - Member ID: _____ Group #: _____	Phone: - - - - - Member ID: _____ Group #: _____

**4. DIAGNOSIS AND CLINICAL INFORMATION**

Needs by Date: / /	Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:
Date of Diagnosis: / /	Has patient received injection training? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> M15.0 Primary (osteo)arthritis <input type="radio"/> Other:	Specialty pharmacy to coordinate home health nursing visit as necessary: <input type="radio"/> Yes <input type="radio"/> No
Height (in/cm): _____ Weight (lb/kg): _____	Agency of choice: <input type="radio"/> Home health nursing coordination is not necessary
Allergies: _____	Reason: <input type="radio"/> MD office administered <input type="radio"/> Home health nursing already coordinated
Current Medications: _____	

**5. PRESCRIPTION INFORMATION**

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="radio"/> Euflexxa	<input type="radio"/> 20 mg/2 ml PFS	<input type="radio"/> Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. <input type="radio"/> Other:		
<input type="radio"/> Gel-One	<input type="radio"/> 30 mg/3 ml PFS	<input type="radio"/> Inject contents of prefilled syringe intra-articularly one time. <input type="radio"/> Other:	1	0
<input type="radio"/> GELSYN-3	<input type="radio"/> 16.8mg/2ml PFS	<input type="radio"/> Inject contents of prefilled syringe intra-articularly once a week for 3 weeks		
<input type="radio"/> Hyalgan	<input type="radio"/> 20 mg/2 ml PFS <input type="radio"/> 20 mg/2ml vial	<input type="radio"/> Inject contents of vial/prefilled syringe intra-articularly once a week for ____ weeks. <input type="radio"/> Other:		
<input type="radio"/> Monovisc	<input type="radio"/> 88mg/4ml PFS	<input type="radio"/> Inject the contents of prefilled syringe intra-articularly one time		
<input type="radio"/> Orthovisc	<input type="radio"/> 30 mg/2 ml syringe	<input type="radio"/> Inject contents of vial/prefilled syringe intra-articularly once a week for ____ weeks. <input type="radio"/> Other:		
<input type="radio"/> Supartz FX	<input type="radio"/> 25 mg/2.5 ml PFS	<input type="radio"/> Inject contents of prefilled syringe intra-articularly once a week for 5 weeks. <input type="radio"/> Other:		
<input type="radio"/> Synvisc	<input type="radio"/> 16 mg/2 ml PFS	<input type="radio"/> Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. <input type="radio"/> Other:		
<input type="radio"/> Synvisc One	<input type="radio"/> 48 mg/6 ml PFS	<input type="radio"/> Inject contents of prefilled syringe intra-articularly one time. <input type="radio"/> Other:	1	0
<input type="radio"/> Include one 23G (for Supartz) or 20G (for all other listed drugs) 15* needle per syringe				

Ancillary supplies and kits will be provided as needed for administration.

**6. PRESCRIBER SIGNATURE**

X _____ / /	X _____ / /
DISPENSE AS WRITTEN	PRODUCT SUBSTITUTION PERMITTED
DATE	DATE

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address or telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.