ivira specialty pharmacy

Orthopedic Referral Form

Please fax completed referral form to ivira:
(302) 499-8729
Please contact office for questions:
(302) 499-8727

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	SECONDARY CONTACT #:
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH: GENDER: ☐ F ☐ M	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ M45.9 - Ankylosing Spondylitis ☐ M17.10 - OA-Knee ☐ M17.11 - Unilateral primary OA, right knee

☐ OTHER:_____ ☐ M17.12 - Unilateral primary OA, left knee

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. PATIENT DEMOGRAPHICS ☐ 3. H & P ☐ 4. MOST RECENT LABS

MEDICATION SELECTION:

MEDICATION	STRENGTH	DIRECTIONS	QTY
EUFLEXXA®	20MG/2ML	☐ INJECT 20 MG INTRA-ARTICULARLY ONCE WEEKLY	☐ 3 SYRINGES ☐ 6 SYRINGES
DUROLANE®	20MG/2ML	☐ INJECT 60 MG (3ML) ONCE	☐ 1 SYRINGES ☐ 2 SYRINGES
GEL-ONE®	30MG/3ML	☐ INJECT 30 MG INTRA-ARTICULARLY ONE TIME	☐ 1 SYRINGES ☐ 2 SYRINGES
GELSYN-3®	16.8MG/2ML	☐ INJECT 16.8 MG (2ML) ONCE WEEKLY FOR 3 WEEKS	☐ 3 SYRINGES ☐ 6 SYRINGES
HYALGAN®	20MG/2ML	☐ INJECT 20 MG INTRA-ARTICULARLY ONCE WEEKLY	☐ 3 SYRINGES ☐ 5 SYRINGES ☐ 6 SYRINGES ☐ 10 SYRINGES
MONOVISC®	88MG/4ML	☐ INJECT 30 MG INTRA-ARTICULARLY ONE TIME	☐ 1 SYRINGES ☐ 2 SYRINGES
ORTHOVISC®	30MG/2ML	☐ INJECT 30 MG INTRA-ARTICULARLY ONCE WEEKLY	☐ ___ SYRINGES
SUPARTZ®	25MG/2.5ML	☐ INJECT 25 MG INTRA-ARTICULARLY ONCE WEEKLY	☐ 3 SYRINGES ☐ 5 SYRINGES ☐ 6 SYRINGES ☐ 10 SYRINGES
SYNVISC®	16MG/2ML	☐ INJECT 16 MG INTRA-ARTICULARLY ONCE WEEKLY	☐ 3 SYRINGES ☐ 6 SYRINGES
SYNVISC-ONE®	48MG/6ML	☐ INJECT 48 MG INTRA-ARTICULARLY ONE TIME	☐ 1 SYRINGES ☐ 2 SYRINGES
VISCO-3™	25MG/2.5ML	☐ INJECT 25 MG INTRA-ARTICULARLY ONCE WEEKLY	☐ 3 SYRINGES ☐ 6 SYRINGES

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

PHYSICIAN SIGNATURE: DATE: