DELTADRUGS

Osteoarthritis

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 818.309.2884 • **FAX:** 818.309.1704 • www.deltadrugs.com

RESET FORM

PATIENT INFORMATION

Patient Name: _____

Address: _____

_____
City, State, Zip Code

Phone #: _____ Secondary Phone #: _____

Patient SSN#: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female

Allergies: _____

Primary Insurance: _____

ID#: _____ Phone #: _____

Secondary Insurance: _____

ID#: _____ Phone #: _____

Ship to: ❑ Patient ❑ Clinic Rx: ❑ New ❑ Refill _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

ICD-10 Diagnosis

- ❑ M17.0 Bilateral primary osteoarthritis of knee
- ❑ M17.10 Unilateral primary osteoarthritis, unspecified knee
- ❑ M17.11 Unilateral primary osteoarthritis, right knee
- ❑ M17.12 Unilateral primary osteoarthritis, left knee
- ❑ M17.2 Bilateral post-traumatic osteoarthritis of knee
- ❑ M17.30 Unilateral post-traumatic osteoarthritis, unspecified knee
- ❑ M17.31 Unilateral post-traumatic osteoarthritis, right knee
- ❑ M17.32 Unilateral post-traumatic osteoarthritis, left knee
- ❑ M17.4 Other bilateral secondary osteoarthritis of knee
- ❑ M17.5 Other unilateral secondary osteoarthritis of knee
- ❑ M17.9 Osteoarthritis of knee, unspecified
- ❑ M79.1 Acute, Painful Musculoskeletal Condition

Date of diagnosis: _____ Years w/ disease: _____

Therapy start date: _____ Therapy stop date: _____

Previous use of NSAIDs:
❑ Meloxicam ❑ Ibuprofen ❑ Naproxen ❑ Diclofenac
Failed due to: ❑ Ulcer of stomach ❑ Irritation of stomach

Previous use of intra-articular corticosteroids: ❑ Triamcinolone
Failed due to: ❑ Pain at injection site ❑ Failure to treat

Previous use of topical pain medications:
❑ Diclofenac 1% Gel ❑ Voltaren gel
Failed due to: ❑ Irritation ❑ Failure to treat

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

MEDICAL RECONCILIATION

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

INJECTABLES INTRA-ARTERIAL

MEDICATION	STRENGTH	DIRECTIONS	FREQ.	INJECTION SITE	QTY	REFILLS
❑ ORTHOVISC®	30mg (2mL)	Inject 30mg once weekly. To be administered intra-articularly by physicians		Knee	❑ 3 weeks ❑ 4 weeks ❑ _____	
❑ MONOVISC®	88mg (4mL)	❑ Inject 140 mg intra-articularly every 2 weeks ❑ Inject 420 mg intra-articularly every 4 weeks		Knee	1 injection	
❑ SYNVISC®	16mg (2mL)	❑ Inject intra-articular once a week (total of 3 injections) ❑ Other: _____		Knee	❑ 3 weeks ❑ 4 weeks ❑ _____	
❑ SYNVISC-ONE®	48mg (3 doses)	❑ Administer as a single intra-articular injection ❑ Other: _____				
❑ EUFLEXXA®						
❑ HYALGAN®						
❑ SUPARTZ®						

Contraindications: knee joint infections, infections, or skin diseases at site of injection, hypersensitivity to gram-positive bacterial proteins (Monovisc, Orthovisc); systemic bleeding disorders (Monovisc)

TOPICAL FLARE-UP PREVENTION

❑ PENNSAID®	2%	Apply 2 pumps (40 grams) twice a day			1 bottle	

ORAL FLARE-UP PREVENTION

❑ DUEXIS®	800/26.6mg	Take one tablet by mouth three times a day			90	
❑ VIMOVO®	375/20mg	Take one tablet by mouth two times a day			60	
	500/20mg	Take one tablet by mouth two times a day			60	

PHYSICIAN INFORMATION

Physician Name: _____ Contact: _____ NPI#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ Fax#: _____ Email: _____

Physician's Signature: _____ Date: _____

I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.

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