euflexxa® 1% SODIUM HYALURONATE

Reimbursement & Pharmacy Support
Patient Enrollment & Prescription Form

Phone: **1-866-EUFLEX1 (1-866-383-5391)**
Fax: **1-866-EUFLEX2 (1-866-383-5392)**
For online benefit information, log on to:
www.euflexxa.com/reimbursement

Patient Information ☐ OK to Contact Patient

Last Name	First Name	SSN	DOB
Home Address	City	State	Zip
Home Phone	Alternate Phone	Gender ☐ Female ☐ Male	

Medical Insurance Information

Primary Insurance:	Phone:	Secondary Insurance:	Phone:
ID Number:	Group Number:	ID Number:	Group Number:

Pharmacy Insurance Information

Pharmacy Insurance Carrier:	Rx Bin:	Secondary Insurance:	Rx Bin:
ID Number:	Group Number:	ID Number:	Group Number:

Provider Information

Prescriber Name:	Licence:	DEA:	NPI:	Tax ID:	PTAN:
Address:	City:	State:	Zip:	Phone:	Fax:

Requested Investigation

☐ Medical benefits (physician's office will supply Euflexxa)
☐ Pharmacy benefits (pharmacy will supply Euflexxa)
☐ Both medical and pharmacy benefits

Clinical Information

ICD-9 Code	Prior Treatments
☐ 715.16 ☐ 715.26 ☐ 715.36 ☐ 715.96 ☐ _____	Has the patient received prior HA treatments ☐ Yes ☐ No Site(s) previously treated ☐ Right Knee ☐ Left Knee ☐ Bilateral Date(s) of prior treatments: _____ Product(s) used: _____
Treatment Sites	**Scheduled Date of Treatment**
☐ Right Knee ☐ Left Knee ☐ Bilateral	

Prescription Information

Choose dosing:

☐ Unilateral

euflexxa® 1% SODIUM HYALURONATE

Directions:

Inject 1 Euflexxa syringe into affected knee weekly for 3 weeks.

Quantity: **3**

Refills: _____

☐ Bilateral

euflexxa® 1% SODIUM HYALURONATE

Directions:

Inject 1 Euflexxa syringe into each knee weekly for 3 weeks.

Quantity: **6**

Refills: _____

PRESCRIBER'S SIGNATURE REQUIRED

MD / NP / PA Signature: _____

*Signature on this form also provides consent to contact this patient's insurance provider for this prescription on the provider's behalf.