SimfaRose
Pharmaceutical Specialties
Your Symphony Of Healthcare • Transition Care Specialist

10016 Pines Blvd
Pembroke Pines, FL 33024
Phone: 888-797-4632
Fax: 844-246-3364
ePrescribe

765 Morris Park Ave
Bronx, NY 10462
Phone: 718-823-6378
Fax: 718-823-6451
ePrescribe

Synvisc Order Form

Today's Date: _____ Date Medication Needed: _____

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Diagnosis/ICD-9 Code:_____ Height / Weight / Allergies: _____

Insurance: _____ ID #: _____

******************Please fax copy of insurance card***************

Medical Criteria

- ❑ Osteoarthrosis, localized, primary, lower leg
- ❑ Osteoarthrosis, localized, secondary, lower leg
- ❑ Osteoarthrosis, localized, not specified whether primary or secondary, lower leg
- ❑ Paint in joint, lower leg
- ❑ Osteoarthrosis, unspecified, lower leg
- ❑ Temporomandibular joint disorder, articular disc disorder
- ❑ Other: _____

Date First Injection Scheduled: _____ Injections Site(s): ❑Left Knee ❑Right Knee ❑Bilateral Knee ❑Other:_____

Tried & Failed: _____ ☑Attached Clinical Notes

℞

❑**Synvisc** ® **2mL(16mg)** of hylan G-F 20 in 2.25mL glass syringe

Sig: ☐Inject intra-articular once a week (one week apart) for total of 3 injections

☐Other: _____

_____

Qty: ☐3 weeks ☐Other: _____ **Refills:** _____

❑**Synvisc-One** ® **3 doses(48mg)** of hylan G-F 20 in 10mL glass syringe

Sig: ☐Administer as single intra-articular injection

☐Other: _____

_____

Qty: ☐3 weeks ☐Other: _____ **Refills:** _____

℞

❑Other: _____

Sig:_____

_____

_____

_____

Qty:_____Weeks

☐Other:_____

Refills: _____

MD Signature (Required):_____Date:_____

MD Name (Printed):_____NPI:_____DEA:_____

Phone:_____Fax:_____Contact:_____

Address:_____City:_____ State:_____ Zip:_____