valeda HEALTH
250 Mount Lebanon Blvd, Suite 208
Pittsburgh, PA 15234
Main: (844) 698-2533 Fax: (844) 733-3779

Navigating your journey with compassionate wisdom

OSTEOARTHRITIS

Fax to: (844) ReferRx
733-3779

Faxed prescriptions will only be accepted from a prescribing practitioner.
Patients must bring an original prescription to the pharmacy.
Prescribers are reminded patients may choose any pharmacy of their choice.
Please contact your Valeda team if you have any questions and/or concerns at (844) 698-2533

1 Patient Information

Patient Name: _____ Phone: _____ **Date Medication Needed:** _____

Soc. Sec. #: _____ DOB: _____ Email: _____ **Ship To:** Patient's Home Prescriber's Office

Address: _____ City: _____ State: _____ ZIP: _____

Alternate Caregiver Information

Alternate Caregiver Name: _____ Phone: _____ Email: _____

2 Prescriber Information

Provider Name: _____ Practice Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ NPI#: _____ DEA: _____ Tax ID#: _____

Practice Contact Information

Practice Contact: _____ Phone: _____ Email: _____

3 Clinical Information

PLEASE FAX *(1) Therapy regimen(s) / schedule, (2) last clinical notes and (3) lab values/scans -- (current and past)*

Diagnosis: _____ ICD-10: _____ Sex: M F (circle one) Height: _____ Weight: _____ lbs. kg. (circle one)

4 Insurance Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

5 Medication

Medication	Dose/Strength	Directions	Qty.	Refills
Euflexxa ®	☐ 20mg/2mL (PFS)	☐ Inject 1 syringe intra-articularly once per week for 3 weeks	☐ 3 syringes (unilateral)	
		☐ Inject 1 syringe intra-articularly bilaterally once per week for 3 weeks	☐ 6 syringes (bilateral)	
Gel-One®	☐ 30mg/3mL (PFS)	☐ Inject 1 syringe intra-articularly into the knee for 1 dose	☐ 1 syringe (unilateral)	
		☐ Inject 1 syringe intra-articularly bilaterally into each knee for 1 dose	☐ 2 syringes (bilateral)	
Hyalgan®	☐ 20mg/2mL (PFS)	☐ Inject 1 syringe intra-articularly once per week	☐ 3 syringes (unilateral) ☐ 5 syringes (unilateral)	
		☐ Inject 1 syringe intra-articularly bilaterally once per week	☐ 6 syringes (bilateral) ☐ 10 syringes (bilateral)	
Supartz FX ®	☐ 25mg/2.5mL (PFS)	☐ Inject 1 syringe intra-articularly once per week	☐ 3 syringes (unilateral) ☐ 5 syringes (unilateral)	
		☐ Inject 1 syringe intra-articularly bilaterally once per week	☐ 6 syringes (bilateral) ☐ 10 syringes (bilateral)	
Synvisc ®	☐ 16mg/2mL (PFS)	☐ Inject 1 syringe intra-articularly once per week for 3 weeks	☐ 3 syringes (unilateral)	
		☐ Inject 1 syringe intra-articularly bilaterally once per week for 3 weeks	☐ 6 syringes (bilateral)	
Synvisc One ®	☐ 48mg/2mL (PFS)	☐ Inject 1 syringe intra-articularly into the knee for 1 dose	☐ 1 syringe (unilateral)	
		☐ Inject 1 syringe intra-articularly bilaterally into each knee for 1 dose	☐ 2 syringes (bilateral)	
OTHER	Dose / Strength:	Directions:	Qty:	Refills:

PATIENT SUPPORT PROGRAMS:
Please sign and date to the right to enroll in the pharmaceutical company assisted patient support program

PATIENT SIGNATURE REQUIRED
Signature Date

This prescription will be filled generically unless the prescriber handwrites "Brand Medically Necessary" or your state specific required language to prohibit substitution:

Prescriber, please sign and date below

PHYSICIAN SIGNATURE REQUIRED
Signature Date

I authorize Valeda RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE:
This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

# of Prescriptions: _____