



Osteoarthritis Enrollment Form

Fax: 909-284-9140
 Phone: 909-266-0016

Urgent Request
 Rep: _____

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____
 Address _____
 Address 2 _____
 City, State, Zip _____
 Home Phone _____ Mobile Phone _____
 DOB _____ Last Four of SS _____ Gender _____
 Language Preference _____

PRESCRIBER INFORMATION

Prescriber Name _____
 DEA _____
 NPI _____
 Address _____
 City, State, Zip _____
 Phone _____ Fax _____
 Contact Person _____

Insurance Information:

Demographic sheet Universal claim form Insurance cards

- Please include demographic sheet along with Universal Claim Form for insurance records or reimbursements (Attach Copies of cards)

Diagnostic Information

M17.0 Bilateral Osteoarthritis of Knees M17.11 Osteoarthritis of Right Knee M17.12 Osteoarthritis of Left Knee Other Diagnosis: _____

Has patient been treated previously for this condition? Yes No Medication(s) failed: _____

Is patient currently on therapy? Yes No Type/Medication(s): _____

Will patient stop taking the above medication(s) before starting the new medication? Yes No If yes, How long should patient wait before starting new medication? _____

Other medications patient is currently taking including OTC medications with dosage and directions (or fax medication profile): _____

Prescription

Medication & Directions	Alternate Dosing	Quantity	Refills
<input type="checkbox"/> Euflexxa 20mg/2ml prefilled syringes <input type="checkbox"/> 3 prefilled syringes <input type="checkbox"/> 6 prefilled syringes Inject 2ml IA into affected knees(s) at weekly intervals <input type="checkbox"/> Bilateral <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee			
<input type="checkbox"/> Hyalgan 29mg/2 ml prefilled syringes <input type="checkbox"/> 3 prefilled syringes <input type="checkbox"/> 6 prefilled syringes Inject 2ml IA into affected knees(s) at weekly intervals <input type="checkbox"/> Bilateral <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee			
<input type="checkbox"/> Orthovisc 30mg/2ml <input type="checkbox"/> 1 prefilled syringe <input type="checkbox"/> 2 prefilled syringes Inject 2ml IA into affected knee(s) one time for 3 weeks <input type="checkbox"/> Bilateral <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee			
<input type="checkbox"/> Supartz 25mg/2.5 ml prefilled syringes Inject 2ml IA into affected knee(s) one time for 3 weeks <input type="checkbox"/> Bilateral <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee			
<input type="checkbox"/> Synvisc One 48mg/6ml prefilled syringes Inject 2 ml IA into affected knee(s) one time for 3 weeks <input type="checkbox"/> Bilateral <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee			
<input type="checkbox"/> Synvisc 16mg/2 ml prefilled syringes Inject 2 ml IA into affected knee(s) one time for 3 weeks <input type="checkbox"/> Bilateral <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee			
<input type="checkbox"/> Others			

Ship to: Patient Office Other _____ Date: _____ Need by Date _____

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution permitted Dispense as Written

Prescriber's Signature: _____ Date: _____

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