Osteoarthritis Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

OARX-20-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ M17.0 Bilateral primary OA of knee
☐ M17.11 Unilateral primary OA, right knee
☐ M17.12 Unilateral primary OA, left knee
☐ Other: _____

History of therapies tried/failed (please include dates):

Is patient new to therapy?: ☐ Yes ☐ No
Diagnosis Date: ____ /____ / ____

Immunization History
☐ Influenza
Date: ____ /____ / ____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Durolane®**	☐ 60 mg/3 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly one time. ☐ Both knees ☐ Left knee ☐ Right knee		
☐ **Euflexxa®**	☐ 20 mg/2 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks ☐ Both knees ☐ Left knee ☐ Right knee ☐ Supplies: Include one 20G 1.5" needle per syringe		
☐ **Gel-One®**	☐ 30 mg/3 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly one time ☐ Both knees ☐ Left knee ☐ Right knee ☐ Supplies: Include one 20G 1.5" needle per syringe		
☐ **Gelsyn-3®**	☐ 16.8 mg/2 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks ☐ Both knees ☐ Left knee ☐ Right knee		
☐ **GenVisc® 850**	☐ 25 mg/3 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for ____ weeks ☐ Both knees ☐ Left knee ☐ Right knee ☐ Supplies: Include one 23G 1.5" needle per syringe		
☐ **Hyalgan®**	☐ 20 mg/2 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for ____ weeks ☐ Both knees ☐ Left knee ☐ Right knee		
☐ **Hymovis®**	☐ 24 mg/3 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 2 weeks ☐ Both knees ☐ Left knee ☐ Right knee ☐ Supplies: Include one 20G 1.5" needle per syringe		
☐ **Monovisc®**	☐ 88 mg/4 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly one time ☐ Both knees ☐ Left knee ☐ Right knee		
☐ **Orthovisc®**	☐ 30 mg/2 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for ____ weeks ☐ Both knees ☐ Left knee ☐ Right knee ☐ Supplies: Include one 20G 1.5" needle per syringe		
☐ **Supartz FX™**	☐ 25 mg/2.5 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for ____ weeks ☐ Both knees ☐ Left knee ☐ Right knee		
☐ **Synvisc®**	☐ 16 mg/2 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks ☐ Both knees ☐ Left knee ☐ Right knee ☐ Supplies: Include one 20G 1.5" needle per syringe		
☐ **Synvisc One®**	☐ 48 mg/6 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly one time ☐ Both knees ☐ Left knee ☐ Right knee ☐ Supplies: Include one 20G 1.5" needle per syringe		
☐ **Visco-3™**	☐ 25 mg/2.5 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks ☐ Both knees ☐ Left knee ☐ Right knee		

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____