Osteoarthritis Enrollment Form

Date: _____ **Needs by Date:** _____

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last Four of SS #: _____ Primary Language: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

☐ M15.0 Osteoarthritis
☐ _____

• Date of Diagnosis: _____

Home Health Coordination:

• Specialty Pharmacy to coordinate home health nursing visit as necessary. ☐Yes ☐No
*Agency of choice: _____
• Home health nursing coordination is not necessary.
Date of administration: _____
Reason: ☐MD office administered
☐Home health nursing already coordinated

Patient Evaluation:

• Does the patient have a complete collapse of the joint space or bone loss? ☐ Yes ☐ No
• Does the patient skin diseases or infection in or around the affected joint? ☐ Yes ☐ No
• If patient has tried simple analgesics, please name and include strength and duration: _____
• Has patient received previous course of treatment with hyaluronidase? ☐ Yes ☐ No
  • If yes, how long ago? _____ months
• Did patient experience pain relief? ☐ Yes ☐ No
• Does the patient have extensive inflammation with joint effusion or an inflammatory flare? ☐ Yes ☐ No
• Has the patient been treated with simple analgesics in the past? ☐ Yes ☐ No
• Unilateral or bilateral treatment? ☐ unilateral ☐ bilateral
• Patient Weight: _____ kg/lbs
• Concomitant Medications: _____
• Allergies: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Orthovisc®	30mg/2ml Syringe	Inject contents of prefilled syringe intra-articularly once a week for _ . ..... weeks.		
☐ Include one 20G 1.5" needle per syringe				
☐ MonoVisc®	88mg/4ml	Inject contents of prefilled syringe intra-articularly one time		
☐ Include one 20G 1.5" needle per syringe/vial				
☐ Euflexxa®	20mg/2ml Prefilled Syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks		
☐ Include one 20G 1.5" needle per syringe				
☐ Supartz®	25mg/2.5ml Prefilled Syringe	Inject contents of prefilled syringe intra-articularly once a week for 5 weeks.		
☐ Include one 23G 1.5" needle per syringe				
☐ Synvisc One™	48mg/6ml Prefilled Syringe	Inject contents of prefilled syringe intra-articularly one time		
☐ Include one 20G 1.5" needle per syringe				
☐ Synvisc®	16mg/2ml Prefilled Syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks.		
☐ Include one 20G 1.5" needle per syringe				

X _____
Physician's Signature (Date)

I authorize pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process.