OsteoArthritis

PRESCRIPTION & ENROLLMENT FORM

❑ New Patient ❑ Current

❶ PATIENT INFORMATION

Patient's Name ____________________

Date of Birth ____________ ❑ Male ❑ Female

Street Address ____________________ Apt# ____________

City ____________________ State ________ Zip ____________

Parent/Guardian (if applicable) ____________________

Home Phone ____________________ Work Phone ____________________

Cell Phone ____________________ Evening Phone ____________________

E-mail address ____________________

Insurance Company Name ____________________

Insurance Company Phone No. ____________________

Insured's Name ____________________

Relationship to Patient ____________________

Identification No. ____________________ Policy/Group No. ____________________

Prescription Card ❑ No ❑ Yes If Yes, Carrier ____________________

Policy No. ____________________ Group No. ____________________

Is patient eligible for Medicare? ❑ No ❑ Yes **Please attach front and back copy of patient's insurance cards, if available.**

❷ PRESCRIBER INFORMATION

Prescriber's Name ____________________

Office Contact ____________________

Clinic / Hospital Affiliation ____________________

Street Address ____________________ Suite # ____________

City ____________________ State ________ Zip ____________

Phone ____________________ Fax ____________________

NPI No. ____________________ License No. ____________________

DEA No. ____________________

Physician Medicaid UPIN No. ____________________

MD Specialty ____________________

To reach your team, call toll-free 1.888.608.9010.

Please fax completed form to the OsteoArthritis team 1.888.302.1028.

❸ CLINICAL INFORMATION

Primary ICD-9 Code: ____________ ____________

Current Weight ____________ kg/lbs Date Recorded

EXPECTED DATE OF FIRST/NEXT INJECTION: _____ DATE OF LAST INJECTION (if applicable): ________

Agency nurse to visit home for injection: ❑ Yes ❑ No

Agency Name & Phone: ____________________

____

Rx:

- ❑ Euflexxa® (hyaluronic acid)
- ❑ Hyalgan® (sodium hyaluronate)
- ❑ OrthoVisc® (hyaluronate sodium)
- ❑ Supartz® (sodium hyaluronate)
- ❑ Synvisc® (hylan G-F 20)

- ❑ Vial
- ❑ Pre-filled Syringe

SIG: Inject Dose: ______ml

Route: ❑ Intra-Articular

Frequency: __________

Dispense Quantity: ____________

Refills: ____________

❑ NKDA ❑ Known Drug Allergies: ____________________

____

Deliver product to: ❑ Office ❑ Patient's Home ❑ Clinic Clinic Location

<u>If shipped to physician's office, physician accepts on behalf of patient for administration in office</u>

By signing below, I certify that the above therapy is medically necessary.

Prescriber's Printed Name ____________________

Prescriber's Signature (sign below) **Date** ____________

____________________ ____________________

Dispense as Written **Substitution Allowed**

(Physician attests this is his/her legal signature. **NO STAMPS)**

OSTA-101107-4