OSTEOARTHRITIS REFERRAL FORM

Updated January 2021

Patient Name ______________________ Today's Date__________ ☐ *NEW* Patient ☐ *CURRENT* Patient
DOB __________ Height ______ Weight ______ ☐ Male ☐ Female Preferred Language __________
Best Phone ________________ Email ______________________
Street Address ______________________ Apt#_____ City ______________ State _____ Zip _______
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address ______________
Allergies ____
Current Medications including OTC's (*please fax a complete list*) ______________________

Please Fax Insurance Card(s) both sides
Insured's Name ______________________
Relation to Patient ______________________
Primary Insurance ______________________
ID# ______________ Group # ______________
Secondary Insurance ______________________
ID# ______________ Group # ______________

Ordering Prescriber ______________________
Office Contact ______________________
Street Address ______________________ Suite #_____
City ______________ State _____ Zip _______
Tel ______________ Fax ______________
Email ______________________
License# ______________________
NPI# ______________________

ICD-10 Code ☐ **M15.0** Osteoarthritis generalized ☐ **M19.90** Osteoarthritis localized primary
☐ **M19.91** Osteoarthritis localized secondary ☐ Other ______________
☐ **Yes (naïve)** ☐ **No** Is Patient treatment naïve? If No, what drugs ______________________ # of Weeks _____
Please forward a copy of all the clinical documents but not limited to following:

- X-Ray performed Last performed Date ______________
- Weight reduction exercise Advised on Date ______________
- Was a Corticosteroid injection was given ? Injection Given Date ______________

Setting of Care: ☐ Physician's Office ☐ Hospital Outpatient Scheduled date of service: ______________
Knee being treated: ☐ Unilateral ☐ Left ☐ Right ☐ Bilateral (Both)
HIP being treated: ☐ Unilateral ☐ Left ☐ Right ☐ Bilateral (Both)
Lower Back being treated: ☐ Yes

PRESCRIPTION

☐ **EUFLEXXA PFS**
SIG: Inject 2 ml IA into affected knee(s) weekly for 3 weeks
☐ QTY 6: Bilateral knees Refill: _______
☐ QTY 3: Left Knee ☐ QTY 3: Right knee Refill: _______

☐ **FORTEO 20 mcg Multi-dose Pen**
SIG: Inject 20 mcg SQ once a day QTY: 1 Pen Refill: _______
PEN NEEDLES ☐ 31 gauge-5mm ☐ 32 gauge-4mm
SIG: Use as directed w/ Forteo QTY: 30 Needles Refill: _______

☐ **HYALGAN PFS**
SIG: Inject 2 ml IA into affected knee(s) weekly for 5 weeks
☐ QTY 10: Bilateral knees Refill: _______
☐ QTY 5: Left Knee ☐ QTY 5: Right knee Refill: _______

☐ **MONOVISC PFS**
SIG: Inject one pre-filled syringe as directed
☐ QTY ___: Bilateral knees Refill: _______
☐ QTY ___: Left Knee ☐ QTY ___: Right knee Refill: _______

☐ **OTHER** ______________________
SIG: ______________________ QTY : _____ Refill: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

☐ **ORTHOVISC PFS**
☐ SIG: Inject 2 ml IA into affected knee(s) weekly for 3 weeks
☐ QTY 6: Bilateral knees Refill: _______
☐ QTY 3: Left Knee ☐ QTY 3: Right knee Refill: _______
☐ SIG: Inject 2 ml IA into affected knee(s) weekly for 4 weeks
☐ QTY 8: Bilateral knees Refill: _______
☐ QTY 3: Left Knee ☐ QTY 3: Right knee Refill: _______

☐ **SUPARTZ FX PFS**
☐ SIG: Inject 2.5 ml IA into affected knee(s) weekly for 3 weeks
☐ QTY 6: Bilateral knees Refill: _______
☐ QTY 3: Left Knee ☐ QTY 3: Right knee Refill: _______
☐ SIG: Inject 2.5 ml IA into affected knee(s) weekly for 5 weeks
☐ QTY 10: Bilateral knees Refill: _______
☐ QTY 5: Left Knee ☐ QTY 5: Right knee Refill: _______

☐ **SYNVISC PFS**
SIG: Inject 2 ml IA into affected knee(s) weekly for 3 weeks
☐ QTY 6: Bilateral knees Refill: _______
☐ QTY 3: Left Knee ☐ QTY 3: Right knee Refill: _______

☐ **SYNVISC One PFS**
SIG: Inject 6 ml IA into affected knee(s) as directed
☐ QTY 2: Bilateral knees Refill: _______
☐ QTY 1: Left Knee ☐ QTY 1: Right knee Refill: _______

Prescriber's Signature (signature required. NO STAMPS)______________________ **Date** __________

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should 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.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

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