

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: _____

SYNISC 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: _____

SYNISC 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.