



Osteoarthritis Enrollment Form

A Dose Of Kindness
With Every Prescription.

Ship to: Patient Office Other: _____ Date: _____ Needs by Date: _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
<i>Please complete the following or send patient demographic sheet</i>	
Patient Name _____	Prescriber's Name _____
Address _____	State License # _____ UPIN _____
Address 2 _____	DEA _____ NPI _____
City, State, ZIP _____	Group/Hospital _____
Home Phone _____	Address _____
Alternate Phone _____	City, State, ZIP _____
DOB _____ Last Four of SS# _____ Gender _____	Phone _____ Fax _____
	Contact Person _____ Phone _____

INSURANCE INFORMATION

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 _____

MEDICAL INFORMATION

Diagnosis	Additional information
<i>Please include diagnosis name and ICD-10</i>	Therapy: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart
<input type="checkbox"/> ICD-10 _____ Diagnosis _____	Weight _____ kg/lbs Height _____ cm/in BSA _____ m ²
Affected Joint:	Allergies _____
<input type="checkbox"/> Right knee	Prior Therapies _____
<input type="checkbox"/> Left knee	Concomitant Medications _____
<input type="checkbox"/> Both knees	Additional Comments _____
Date of Diagnosis _____	Treatment Start Date _____ Treatment End Date _____

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Quantity	Refills
<input type="checkbox"/> Euflexxa	2mL syringe			
<input type="checkbox"/> Hyalgan	2mL syringe			
<input type="checkbox"/> Orthovisc	2mL syringe			
<input type="checkbox"/> Supartz	2.5mL syringe			
<input type="checkbox"/> Synvisc	2mL syringe			
<input type="checkbox"/> Synvisc One	6mL syringe			

Prescriber's Signature _____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

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