Gigi Specialty Pharmacy

Osteoarthritis Enrollment Form

A Dose Of Kindness With Every Perscription.

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

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____

Address _____

Address 2 _____

City, State, ZIP _____

Home Phone _____

Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

PRESCRIBER INFORMATION

Prescriber's Name _____

State License # _____ UPIN _____

DEA _____ NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

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

Please include diagnosis name and ICD-10

☐ ICD-10 _____ Diagnosis _____

Affected Joint:

☐ Right knee

☐ Left knee

☐ Both knees

Date of Diagnosis _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in BSA _____ m^2

Allergies _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

Treatment Start Date _____ Treatment End Date _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Euflexxa	2mL syringe			
☐ Hyalgan	2mL syringe			
☐ Orthovisc	2mL syringe			
☐ Supartz	2.5mL syringe			
☐ Synvisc	2mL syringe			
☐ Synvisc One	6mL syringe			

Prescriber's Signature _____ *PRODUCT SUBSTITUTION PERMITTED* _____ *DISPENSE AS WRITTEN*