

## Osteoarthritis Enrollment Form

Specialty Pharmacy Enrollment Form Reason Re

PATIENT INFORMATIO	N		PRESCRIBER I	NFORMATION			
Please complete the following or send patient demographic sheet							
Patient Name			Prescriber's Name				
Address			DEA				
Address 2							
City, State, ZIP							
Home Phone							
Alternate Phone							
DOB Last Four of SS# Gender			Phone		Fax		
Language Pref: 🗌 English 🔲 Spanish 🔲 Other			Contact Person		Phone		
INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)							
	Prior Authorization Reference number						
MEDICAL INFORMATION	ON (Section must be complete	ed to p	orocess prescriptio	<b>n)</b> (Attach separate s	heet if needed)		
	diagnosis name with ICD-10 code				Reauthorization Restart		
☐ ICD-10		We	Weightkg/lbs Heightcm/in BSAm²				
Description		- 1	Allergies				
Affected Joint:		- 1	<u> </u>				
<u> </u>		- 1	Prior Therapies				
Right knee		Cor	Concomitant Medications				
Left knee		-					
Both knees		Add	Additional Comments				
Date of Diagnosis		-   —					
Butto of Bridginsons			Treatment Start Date Treatment End Date				
		Trea	atment Start Date	Treatmo	ent End Date		
PRESCRIPTION INFOF	RMATION	Tre	atment Start Date	Treatm	ent End Date		
PRESCRIPTION INFOR	RMATION  Dose/Strength	Tre:	atment Start Date  Directions	Treatm	ent End Date	Refills	
	Dose/Strength		Directions		Quantity		
Medication	Dose / Strength		Directions		Quantity		
Medication  ☐ DUROLANE®  ☐ Euflexxa®	Dose / Strength		Directions		Quantity		
Medication  ☐ DUROLANE®  ☐ Euflexxa®  ☐ Gel-One®	Dose/Strength		Directions		Quantity		
Medication  ☐ DUROLANE®  ☐ Euflexxa®  ☐ Gel-One®  ☐ GELSYN-3®	Dose/Strength		Directions		Quantity		
Medication  ☐ DUROLANE®  ☐ Euflexxa®  ☐ Gel-One®	Dose/Strength		Directions		Quantity		
Medication  DUROLANE®  Euflexxa®  Gel-One®  GELSYN-3®	Dose/Strength		Directions		Quantity		
Medication  DUROLANE®  Euflexxa®  Gel-One®  GELSYN-3®  GenVisc 850®	Dose/Strength		Directions		Quantity		
Medication  DUROLANE®  Euflexxa®  Gel-One®  GELSYN-3®  GenVisc 850®  Hyalgan®  Hymovis®	Dose/Strength		Directions		Quantity		
Medication  DUROLANE®  Euflexxa®  Gel-One®  GELSYN-3®  GenVisc 850®  Hyalgan®  Hymovis®  Monovisc®	Dose/Strength		Directions		Quantity		
Medication  DUROLANE®  Euflexxa®  Gel-One®  GELSYN-3®  GenVisc 850®  Hyalgan®  Hymovis®  Monovisc®  Orthovisc®	Dose/Strength		Directions		Quantity		
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Medication  □ DUROLANE® □ Euflexxa® □ Gel-One® □ GELSYN-3® □ GenVisc 850® □ Hyalgan® □ Hymovis® □ Monovisc® □ Orthovisc® □ Supartz FX® □ Synvisc One® □ VISCO-3™  *Prescriber Authorization: I authorize this pharm behalf as my authorized agent, including the received.	Dose/Strength  nacy and its representatives to act as my authorized agent to sceipt of any required prior authorization forms and the receipt of any required prior authorization forms and authorization forms are also any authorization forms and authorization forms are also any authorization forms and authorization fo	to secure cove	Directions  Directions	r authorization process for my patier	Quantity  Output  Outp	Refills  Ty forms on my unable to fulfill	
Medication  □ DUROLANE® □ Euflexxa® □ Gel-One® □ GELSYN-3® □ GenVisc 850® □ Hyalgan® □ Hymovis® □ Monovisc® □ Orthovisc® □ Supartz FX® □ Synvisc One® □ VISCO-3™  **Prescriber Authorization: I authorize this pharma behalf as my authorized agent, including the recthis prescription, I further authorize this pharma.	Dose/Strength	to secure cove	Directions  Directions	r authorization process for my patier patient data. In the event that this pacy of the patient's choice or in the	Quantity  Output  Outp	Refills  Ty forms on my unable to fulfill	
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