briovaRx®

Fax: Select Option

Phone: Select Option

# Osteoarthritis Enrollment Form

## 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 _____

Language Pref: ☐ English ☐ Spanish ☐ Other _____

## PRESCRIBER INFORMATION

Prescriber's Name _____

DEA _____

NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

## INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number _____

## MEDICAL INFORMATION *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

**Diagnosis —** *Please include diagnosis name with ICD-10 code*

☐ ICD-10 _____

Description _____

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 |
|---|---|---|---|---|
| ☐ DUROLANE® | | | | |
| ☐ Euflexxa® | | | | |
| ☐ GELSYN-3® | | | | |
| ☐ Hyalgan® | | | | |
| ☐ Hymovis® | | | | |
| ☐ Orthovisc® | | | | |
| ☐ Supartz FX® | | | | |
| ☐ Synvisc® | | | | |
| ☐ Synvisc One® | | | | |

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

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

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature _____ Date _____

Supervising physician _____ Date _____