Osteoarthritis Enrollment Form

Express Health Mart Pharmacy
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6 Simple steps to submitting a referral

1 PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐Male ☐Female
E-mail: _____
Last Four of SS #: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

3 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

☐ 715.0 Osteoarthritis
☐ Other: _____
Height: _____
Weight: _____
Allergies: _____

Needs by Date: _____
Ship to: ☐ Patient ☐Office ☐ Other: _____
Has patient received injection training? ☐ Yes ☐No
Specialty Pharmacy to coordinate Home Health nursing visit as necessary ☐ Yes ☐No
Agency of choice: _____
☐ Home Health nursing coordination is not necessary
Date of administration: _____
Reason: ☐ MD office administered ☐Home Health nursing already coordinated

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Euflexxa®	☐ 20mg/2ml Prefilled Syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. ☐ Other: _____		
☐ Include one 20G 1.5" needle per syringe				
☐ Gel-One®	☐ 30mg/3ml Pre-filled Syringe	☐ Inject contents of prefilled syringe intra-articularly one time ☐ Other: _____	1	0
☐ Include one 20G 1.5" needle per syringe				
☐ Hyalgan®	☐ 20mg/2ml Prefilled Syringe ☐ 20mg/2ml Vial	☐ Inject contents of prefilled syringe/vial intra-articularly once a week for _____ weeks. ☐ Other: _____		
☐ Include one 20G 1.5" needle per syringe/vial				
☐ Orthovisc®	☐ 30mg/2ml Syringe	☐ Inject contents of prefilled syringe/vial intra-articularly once a week for _____ weeks. ☐ Other: _____		
☐ Include one 20G 1.5" needle per syringe				
☐ Supartz®	☐ 25mg/2.5ml Prefilled Syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 5 weeks. ☐ Other: _____		
☐ Include one 23G 1.5" needle per syringe				
☐ Synvisc One™	☐ 48mg/6ml Prefilled Syringe	☐ Inject contents of prefilled syringe intra-articularly one time ☐ Other: _____	1	0
☐ Include one 20G 1.5" needle per syringe				
☐ Synvisc®	☐ 16mg/2ml Prefilled Syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. ☐ Other: _____		
☐ Include one 20G 1.5" needle per syringe				
☐				

☐ Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

X _____ (Date)
DISPENSE AS WRITTEN

X _____ (Date)
PRODUCT SUBSTITUTION PERMITTED