Fax Referral To: 814-283-2211

Phone 855-265-8008

1333 Plank Road, Suite 200, Duncansville, PA 16635

Osteoarthritis Enrollment Form

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other**

Date: ______________ **Needs by date:** __________

Is patient new to this therapy? ☐ **YES** ☐ **NO**

Documents necessary for facilitation of referral:

1. **Enrollment form**
2. **Front/Back copies of all insurance/prescription cards**
3. **Copy of most recent labwork and medication profile**

PATIENT INFORMATION

(Complete the following ***or send patient demographic sheet****)*

Patient Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Home Phone: ______________________

Alternate Phone: ______________________

SS #: ______________________

Date of Birth: __________ Gender: __________

PRESCRIBER INFORMATION

Prescriber's Name: ______________________

NPI #: ______________

DEA #: ______________ State License #: __________

Group or Hospital: ______________________

Address: ______________________

City, State Zip: ______________________

Phone: ______________ Fax: ______________

Contact Person: ______________ Phone: __________

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

Please include diagnosis name and ICD-10:

____

____

____

____

Date of primary dx: ______________

Additional Clinical Information:

Weight: ________ kg/lbs • Height: __________ in/cm

Allergies: ______________________

Failed Therapies: ______________________

Dates of previous therapies: ______________________

Reason(s) for discontinuation: ______________________

Desired start date of therapy: ______________________

PREVIOUS INJECTION THERAPY HISTORY

Please include dates and results:

☐ **Euflexxa 2ml (1 dose) to be injected intra-articular in: knees one time each week for 3 weeks.**	☐**RIGHT**	☐ **LEFT**	☐ **BILATERAL**
☐ **Hyalgan – 2ml (1 dose) to be injected intra-articular in: knees one time each week for _____ weeks.**	☐**RIGHT**	☐ **LEFT**	☐ **BILATERAL**
☐ **Monovisc – 4ml to be injected intra-articular in: knees as a single injection.**	☐**RIGHT**	☐ **LEFT**	☐ **BILATERAL**
☐ **Orthovisc – 2ml (1 dose) to be injected intra-articular in: knees one time each week for 3 weeks.**	☐**RIGHT**	☐ **LEFT**	☐ **BILATERAL**
☐ **Synvisc ONE – 6ml (3 x 2ml doses) to be injected intra-articular in: knees as a single injection.**	☐**RIGHT**	☐ **LEFT**	☐ **BILATERAL**
☐ **Synvisc – 2ml (1 dose) to be injected intra-articular in: knees one time each week for 3 weeks.**	☐**RIGHT**	☐ **LEFT**	☐ **BILATERAL**

QUANTITY AND REFILLS: **Dispense # _________ with ___________ refills.**

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said processes.

____

Physician Signature (Date)

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right

☐