Osteoarthritis Enrollment Form

Phone: 800-476-7496
Fax: 888-985-9223

SINCE 1933 BOOTHWYN PHARMACY

PATIENT INFORMATION				
Patient Name (Last, First, Mi)			☐ Male ☐ Female	
Date of Birth	SS#	Phone (Home)	(Work)	
Address		City	State	Zip

INSURANCE INFORMATION (PLEASE ATTACH COPY OF PATIENT CARD – FRONT AND BACK)		
Primary Insurance		Policy Holder
Policy #	Group #	Phone

DIAGNOSIS / MEDICAL INFORMATION (Please indicate primary and secondary diagnosis)			
☐ ICD Code 715.0 Osteoarthritis	☐ ICD Code & Name: _____	Which knee is being treated? ☐ Left ☐ Right ☐ Both	Is patient new to therapy? ☐ yes ☐ no Date of Diagnosis:
Patient Weight: _____		Drug Allergies: _____ OR ☐ NKDA	

PREVIOUS MEDICATIONS (Please specify dosage and time on therapy)		
Medication Strength and Dose	*Date of Therapy*	*Reason for Discontinuing*

PRESCRIPTION INFORMATION				
MEDICATION	STRENGTH	SIG / DIRECTIONS	QUANITY	REFILLS
☐ **Euflexxa ®**	☐ 20mg/2ml Prefilled Syringe ☐ Include One 20G 1.5" needle	☐ Inject contents Intra-Articularly once a week for 3 weeks ☐ Other: _____	_____	_____
☐ **Gel-One ®**	☐ 30mg/3ml Prefilled Syringe ☐ Include One 20G 1.5" needle	☐ Inject contents Intra-Articularly one time ☐ Other: _____	1	0
☐ **Hyalgan ®**	☐ 20mg/2ml Prefilled Syringe ☐ 20mg/2ml Vial ☐ Include One 20G 1.5" needle	☐ Inject contents Intra-Articularly once a week for _____ weeks ☐ Other: _____	_____	_____
☐ **Orthovisc ®**	☐ 30mg/2ml Prefilled Syringe ☐ Include One 20G 1.5" needle	☐ Inject contents Intra-Articularly once a week for _____ weeks ☐ Other:	_____	_____
☐ **Supartz ®**	☐ 25mg/2.5ml Prefilled Syringe ☐ Include One 23G 1.5" needle	☐ Inject contents Intra-Articularly once a week for 5 weeks ☐ Other: _____	_____	_____
☐ **Synvisc ®**	☐ 16mg/2ml Prefilled Syringe ☐ Include One 20G 1.5" needle	☐ Inject contents Intra-Articularly once a week for 3 weeks ☐ Other: _____	_____	_____
☐ **Synvics One ™**	☐ 48mg/6 ml Prefilled Syringe ☐ Include One 20G 1.5" needle	☐ Inject contents Intra-Articularly one time ☐ Other: _____	1	0
☐ **Other**	☐	☐	_____	_____

DELIVERY AND PATIENT EDUCATION INSTRUCTIONS	
☐ Physician's Office / Clinic	Date Needed: _____ / _____ / _____

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION			
Physician Name	License #	DEA #	UPIN#
Office Contact	Phone	Fax	NPI#
Address		City/State/Zip	
Physician's Signature (required)		Date (required)	

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