



Osteoarthritis Enrollment Form

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Authorized Contact: _____ Contact's Phone: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 ID: _____ Group#: _____ ID: _____ Group#: _____

Clinical Information

Please attach clinical notes, therapy history, and medication list to expedite the prior authorization.

Diagnosis: _____ ICD 10 code: _____
 Secondary Diagnosis: _____ ICD 10 code: _____
 Has patient had prior treatment for this diagnosis? Yes No Scheduled Injection Date: ____/____/____
 Date(s) of previous therapy and medication: _____

Prescription

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> DUROLANE®	60 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use in <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilaterally		
<input type="checkbox"/> Euflexxa®	20 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use in <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilaterally		
<input type="checkbox"/> GELSYN-3™	16.8 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use in <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilaterally		
<input type="checkbox"/> Hyalgan®	<input type="checkbox"/> 20 mg/2 mL prefilled syringe <input type="checkbox"/> 20 mg/2 mL vial	Inject contents of prefilled syringe/vial intra-articularly once a week for 5 weeks. Patient to use in <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilaterally		
<input type="checkbox"/> Monovisc®	88 mg/4 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use in <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilaterally		
<input type="checkbox"/> Orthovisc®	30 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for ____ weeks. Patient to use in <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilaterally		
<input type="checkbox"/> Synvisc®	16 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use in <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilaterally		
<input type="checkbox"/> Synvisc-One®	48 mg/6 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use in <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> bilaterally		

Is patient new to this therapy? YES NO | Ship to: Patient Office Other | Desired Start Date: _____

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
 Practice Name: _____ Contact: _____ Preferred Method: Phone Fax Email
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Email: _____

My signature below authorizes Restore Rx, Inc. 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 Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____ This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.

fax referral to: **901-388-0407** | phone: **877-388-0507** | **www.restorerx.com**