Osteoarthritis Enrollment Form

Date:_____

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Authorized Contact: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs ☐ kg ☐
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Contact's Phone: _____

Ins. Data

Primary Insurance: _____
ID: _____ Group#: _____

Secondary Insurance: _____
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 treament for this diagnosis? ☐ Yes ☐ No Scheduled Injection Date: _____/_____/_____
Date(s) of previous therapy and medication: _____

Prescription

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

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

Prescriber Data

Prescriber Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____ Preferred Method: ☐ Phone ☐ Fax ☐ Email
Phone: _____ Fax: _____
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.