Osteoarthritis Enrollment Form

Whole Health Pharmacy

Fax: 949-340-8008
Phone: 949-305-0788
□ **Urgent Request**
Rep: _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
*Please complete the following or **send patient demographic sheet***	
Patient Name _____	Prescriber Name _____
Address _____	DEA _____
Address 2 _____	NPI _____
City, State, Zip _____	Address _____
Home Phone _____ Mobile Phone _____	City, State, Zip _____
DOB _____Last Four of SS _____ Gender _____	Phone _____ Fax _____
Language Preference _____	Contact Person _____

Insurance Information:

□ Demographic sheet □ Universal claim form □ Insurance cards

- Please include demographic sheet along with Universal Claim Form for insurance records or reimbursements (Attach Copies of cards)

Diagnostic Information

□ M17.0 Bilateral Osteoarthritis of Knees □ M17.11 Osteoarthritis of Right Knee □ M17.12 Osteoarthritis of Left Knee □ Other Diagnosis: _____

Has patient been treated previously for this condition? □ Yes □ No Medication(s) failed: _____

Is patient currently on therapy? □ Yes □ No Type/Medication(s): _____

Will patient stop taking the above medication(s) before starting the new medication? □ Yes □ No If yes, How long should patient wait before starting new medication? _____

Other medications patient is currently taking including OTC medications with dosage and directions (or fax medication profile):
_____

Prescription

Medication & Directions	Alternate Dosing	Quantity	Refills
□ Euflexxa 20mg/2ml prefilled syringes □ 3 prefilled syringes □ 6 prefilled syringes			
Inject 2ml IA weekly x 3 weeks into □ Bilateral □ Left Knee □ Right Knee			
□ Hyalgan 29mg/2 ml prefilled syringes □ 3 prefilled syringes □ 6 prefilled syringes			
Inject 2ml IA weekly x 3 weeks into □ Bilateral □ Left Knee □ Right Knee			
□ Orthovisc 30mg/2ml □ 1 prefilled syringe □ 2 prefilled syringes			
Inject 2ml IA weekly x 3 weeks into □ Bilateral □ Left Knee □ Right Knee			
□ Supartz 25mg/2.5 ml prefilled syringes □ 3 prefilled syringes □ 6 prefilled syringes			
Inject 2ml IA weekly x 3 weeks into □ Bilateral □ Left Knee □ Right Knee			
□ Synvisc One 48mg/6ml prefilled syringes □1 prefilled syringe □2 prefilled syringes			
Inject 6ml IA one time only into □ Bilateral □ Left Knee □ Right Knee			
□ Synvisc 16mg/2 ml prefilled syringes □ 3 prefilled syringes □ 6 prefilled syringes			
Inject 2 ml IA weekly x 3 weeks into □ Bilateral □ Left Knee □ Right Knee			
□ Others			

Ship to: □ Patient □ Office □ Other _____ Date: _____ Need by Date _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

□ Product Substitution permitted □ Dispense as Written

Prescriber's Signature: _____Date: _____