OSTEOARTHRITIS Enrollment Form

SKYEMED PHARMACY & INFUSION SERVICES

Phone: 866-778-8255
Fax: 800-432-6614
pharmacy@skyemed.com

Deliver Medications To: ☐ Patient's Home ☐ Doctor's Office Date Needed By: _____

PATIENT DEMOGRAPHICS

Last Name: First Name: Date of Birth:

Street Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Prescription Insurance: PLEASE ATTACH A COPY OF THE FRONT AND BACK OF THE PATIENT'S CARD

Primary Prescription Insurance: _____ Rx BIN: _____ Rx PCN: _____

Patient ID/Policy Number: _____ Patient Rx Group Number: _____

PATIENT CLINICAL INFORMATION/HISTORY: (PLEASE ATTACH A COPY OF PATIENT'S RECENT CHART NOTES, PATHOLOGY AND LABS)

Diagnosis: _____ ICD-10 Code(s): _____

Affected Joint:
- ☐ Right Knee
- ☐ Left Knee
- ☐ Both Knees

Therapy:
- ☐ New
- ☐ Reauthorization
- ☐ Restart

Date of Diagnosis: _____

Weight _____kg/lbs Height _____ BSA _____m2

Allergies: _____

Prior Therapies: _____

Concomitant Medications: _____

_____

Additional Comments: _____

_____

Treatment Start Date: _____ Treatment End Date: _____

PRESCRIPTION INFORMATION

DRUG	STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Supartz	☐ 25mg/2.5mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 5 weeks ☐ Other: _____		
☐ Euflexxa	☐ 20mg/2mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks ☐ Other: _____		
☐ Hyalgan	☐ 20mg/2mL prefilled syringe ☐ 20mg/2mL vial	☐ Inject contents of prefilled syringe/vial intra-articularly once a week for _____ weeks ☐ Other: _____		
☐ Orthovisc	☐ 30mg/2mL syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for _____ weeks ☐ Other: _____		
☐ Synvisc	☐ 16mg/2mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks ☐ Other: _____		
☐ Synvisc One	☐ 48mg/6mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly one time ☐ Other: _____		

PRESCRIBER INFORMATION

Prescriber Name: Facility Group or Hospital:

Street Address: City: State: Zip:

Office Phone: Office Fax: Office Contact:

DEA: NPI: UPIN:

Physician Signature: _____ Date: _____