SUPARTZ FX sodium hyaluronate

Enrollment Form

SKYEMED PHARMACY & INFUSION SERVICES

Pharmacy Phone: 866-778-8255
Pharmacy Fax: 800-432-6614
orthopedic@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 copy of patient's recent chart notes, pathology and labs)

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

☐ **Right Knee** ☐ **Left Knee** ☐ **Bilateral Knees**

Weight: _____**kg/lbs Height:** _____**cm/in BSA:** _____**m2**

Allergies: _____

1. Has the patient failed 3 months of conservative treatment? ☐ **Yes** ☐ **No**

2. Has the patient received intra-articular steroid injections of the knee? ☐ **Yes** ☐ **No If yes, please provide dates** _____

3. Has the patient previously been treated with sodium hyaluronate therapy or is intolerant to other JFT products? ☐**Yes** ☐**No**

If yes, name the product(s) and date range(s) of treatment _____

If yes, has the patient had a reduction of pain with previous treatment? ☐ **Yes** ☐ **No**

4. X-ray dates confirming diagnosis? _____

5. Other relevant clinical information _____

Prescription Information

SUPARTZ FX sodium hyaluronate

STRENGTH

25mg/2.5mL prefilled syringe

DIRECTIONS

Inject contents of prefilled syringe intra-articularly into knee once a week for:

☐ **3 weeks**

☐ **4 weeks**

☐ **5 weeks**

QUANTITY **REFILLS**

bioventus®

Active Healing Through Orthobiologics

Prescriber Name: Facility Group or Hospital:

Street Address: City: State: Zip:

Office Phone: **Office Fax:** **Office Contact:**

DEA: NPI: UPIN: State License:

Physician Signature: _____ **Date:** _____