SMP PHARMACY SOLUTIONS

Fax#: 855-447-6637
Ph#: 855-650-5009

Osteoarthritis Prescription Faxable

Today's Date: _____ **Needed by:** _____ **Name:** _____ **Phone:** _____

Patient Demographic: (Provide the following or attached demographic sheet)
Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Alt. Phone: _____
SS#: _____ Date Birth: _____
Gender: _____ Height: _____ Weight _____ BSA _____ m2

Prescriber: (Provide as much information as possible)
Prescriber's Name: _____ Group/Hospital: _____
Specialty: _____ NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Alt. Contact Name: _____
Phone: _____ Position: _____

Insurance Information (Please copy and attach the front and back of the Insurance Card):
Primary Insurance Name: _____ ID# _____ BIN#: _____ Group#: _____ PCN#: _____ Phone: _____
☐ No Insurance ☐ Patient will pay out of pocket ☐ Enroll in Manufacturer's Patient Assistance Program

Medication Delivery to (Choose Only One):
☐ Patient Address ☐ First Fill Physician's Office, Refill to Patient Address ☐ Patient will pick up at Pharmacy

Diagnosis (ICD-10 code):
☐ M15.8 Osteoarthritis generalized Multiple joints ☐ M15.9 Polyosteoarthritis, unspecified ☐ M17.0 Bilateral primary OA of knee
☐ M17.10 Unilateral primary OA, unspecified knee ☐ M17.11 Unilateral primary OA, right knee ☐ M17.12 Unilateral primary OA, left knee
☐ M17.2 Bilateral post-traumatic OA of knee ☐ M17.30 Unilateral post-traumatic OA, unspecified knee
☐ M17.31 Unilateral post-traumatic OA, right knee ☐ M17.32 Unilateral post-traumatic OA, left knee ☐ M17.4 Other bilateral secondary OA of knee
☐ M17.5 Other unilateral secondary OA of knee ☐ M17.9 OA of knee, unspecified ☐ Other _____

Injection Training & Educational Needs: ☐ Specialty Pharmacy Injection Training Requested ☐ Manufacturer's Patient Assistance Program Enrollment Requested **OR** (Please Choose only one) ☐ Physician's Office already trained Patient ☐ Patient is already independently Injecting

Patient Allergies/ Allergic reactions
1. _____
2. _____

Prior (Failed) Medications (Reason for D/C)
1. _____
2. _____

Medication	Dose	Direction	Patient to Use	Qty.	Ref.
☐ **Euflexxa®**	10mg/ml	Inject to affected knee(s) once a week.	☐ Unilateral ☐ Bilateral		
☐ **Gel-One®**	30mg/3ml	Inject to affected knee(s) once.	☐ Unilateral ☐ Bilateral		
☐ **GELSYN-3®**	16.8mg/2ml	Inject to affected knee(s) once a week.	☐ Unilateral ☐ Bilateral		
☐ **GenVisc 850®**	25mg/3ml	Inject to affected knee(s) once a week.	☐ Unilateral ☐ Bilateral		
☐ **Hyalgan®**	20mg	Inject to affected knee(s) once a week.	☐ Unilateral ☐ Bilateral		
☐ **Hymovis®**	24mg/3ml	Inject to affected knee(s) once a week.	☐ Unilateral ☐ Bilateral		
☐ **Monovisc®**	88mg/4ml	Inject to affected knee(s) once.	☐ Unilateral ☐ Bilateral		
☐ **Orthovisc®**	30mg/2ml	Inject to affected knee(s) once a week.	☐ Unilateral ☐ Bilateral		
☐ **Supartz FX®**	25mg/2.5ml	Inject to affected knee(s) once a week.	☐ Unilateral ☐ Bilateral		
☐ **Synvisc One®**	8mg/ml	Inject to affected knee(s) once.	☐ Unilateral ☐ Bilateral		
☐ **Synvisc®**	8mg/ml	Inject to affected knee(s) once a week.	☐ Unilateral ☐ Bilateral		

By signing this form and utilizing our services, you are authorizing SMP and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

_____ _____/_____/_____
Prescriber Signature Date