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 _____

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		
☐ **Other**					

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