SMP PHARMACY SOLUTIONS

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

Osteoarthritis Prescription Faxable

Patient Demographic: *Provide the following or attach demographic sheet*

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

SS#: _____ Date of 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: _____

Contact Name: _____ Phone: _____

Insurance Information - Please provide a copy of the front and back of the insurance card.

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