Parkway
SPECIALTY PHARMACY

Osteoarthritis Enrollment Form

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PATIENT INFORMATION

Name:	Date of Birth:	O Male O Female
Address:	City: State:	Zip:
Phone:	Alt Phone:	Email:
SS #:	Primary Language:	Emergency Contact:

PRESCRIBER INFORMATION

Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Fax:			Office Contact:

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

Prior Failed Medication(s):	Length of Treatment	Reason for Discontinuing
	_____/_____/_____-_____/_____/_____	
	_____/_____/_____-_____/_____/_____	
	_____/_____/_____-_____/_____/_____	

Date of Diagnosis: _____/_____/_____

O M15.0 Osteoarthritis generalized

O M19.90 Osteoarthritis localized primary

O M19.91 Osteoarthritis localized secondary

O Other: _____

Last X-Ray Date: _____/_____/_____

Any changes with the latest X-Ray?

O Yes

O No

Allergies:

Height:_____ in/cm

Weight: _____ kg/lbs

PRESCRIPTION INFORMATION

Needs by Date:

Drug	Dose	Direction & Quantities	Refills
Euflexxa®	O Pre-filled Syringe	O Inject 2mL IA **into each knee** at weekly intervals for **3 weeks** (Quantity: 6) O Inject 2mL IA into O **Left knee** OR O **Right knee** at weekly intervals for **3 weeks** (Quantity: 3)	
Gel-One®	O Pre-filled Syringe	O Inject 3mL IA **into each knee** as directed (Quantity: 2) O Inject 3mL IA into O **Left knee** OR O **Right knee** as directed (Quantity: 1)	
Hyalgan®	O Pre-filled Syringe O Vials	O Inject 2mL IA **into each knee** at weekly intervals for **5 weeks** (Quantity: 10) O Inject 2mL IA into O **Left knee** OR O **Right knee** at weekly intervals for **5 weeks** (Quantity: 5)	
Hymovis®	O Pre-filled Syringe	O Inject 3mL IA **into each knee** at day 0 and day 7. (Quantity: 4) O Inject 3mL IA into O **Left knee** OR O **Right knee** at day 0 and day 7 (Quantity: 2)	
Orthovisc®	O Pre-filled Syringe	O Inject 2ml IA **into each knee** at weekly intervals for **3 weeks** (Quantity: 6) O Inject 2mL IA into O **Left knee** OR O **Right knee** at weekly intervals for **3 weeks** (Quantity: 3) O Inject 2ml IA **into each knee** at weekly intervals for **4 weeks** (Quantity: 8) O Inject 2mL IA into O **Left knee** OR O **Right knee** at weekly intervals for **4 weeks** (Quantity: 4)	
Supartz FX®	O Pre-filled Syringe	O Inject 2.5ml IA **into each knee** at weekly intervals for **3 weeks** (Quantity: 6) O Inject 2.5mL IA into O **Left knee** OR O **Right knee** at weekly intervals for **3 weeks** (Quantity: 3) O Inject 2.5ml IA **into each knee** at weekly intervals for **5 weeks** (Quantity: 10) O Inject 2.5mL IA into O **Left knee** OR O **Right knee** at weekly intervals for **5 weeks** (Quantity: 5)	
Synvisc®	O Pre-filled Syringe	O Inject 2mL IA **into each knee** at weekly intervals for **3 weeks** (Quantity: 6) O Inject 2mL IA into O **Left knee** OR O **Right knee** at weekly intervals for **3 weeks** (Quantity: 3)	
Synvisc-One®	O Pre-filled Syringe	O Inject 6mL IA **into each knee** as directed. (Quantity: 2) O Inject 6mL IA into O **Left knee** OR O **Right knee** as directed (Quantity: 1)	
Monovisc®	O Pre-filled Syringe	O Inject one pre-filled syringe **into each knee** as directed. O Inject one pre-filled syringe into **O Left knee** OR **O Right knee**	

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: Date

CONFIDENTIALITY NOTICE

Faxed Prescriptions will only be accepted from a prescribing practitioner.