



OsteoArthritis Enrollment Form
Patient Referral/Medication Request Form

Phone: 806-324-5447 • Toll Free Phone 1-866-629-6779 • Toll Free Fax: 1-866-217-8034

Patient Information

Patient Name
Date of Birth Male Female
Address Apt #
City State Zip
Phone Home Work Cell
Social Security #
Allergies NKA
Weight kg lb
Emergency Contact Name
Phone
Please attach copy of insurance information or copy of insurance cards (both sides).

Shipping Information

Patient's Home Physician's Office
Other
Date Medication Needed

Physician Information

Physician Name
Office Contact Name
Address
City State Zip
Phone Fax
Physician Signature
Date
Dispense as written Generic substitution permitted

Diagnosis/Medical Information

ICD9 Code:
715.16 Osteoarthritis, localized, primary, lower leg
715.26 Osteoarthritis, localized, secondary, lower leg
715.36 Osteoarthritis, localized, not specified primary or secondary, lower leg
715.90 Osteoarthritis, unspecified generalized or localized site
715.96 Osteoarthritis, unspecified generalized or localized, lower leg
716.90 Unspecified Arthropathy, site unspecified
Other (include code)
Diagnosis Description

Please specify leg(s) to be injected

Right Left Both

Prescription Information

Euflexxa (Sodium Hyaluronate) 20mg/2.0ml each
Supartz (Sodium Hyaluronate) 25mg/2.5ml each
Hyalgan (Sodium Hyaluronate) 20mg/2.0ml each
Synvisc (Hylan G-F 20) 16mg/2.0ml each
Orthovisc (Hyaluronan) 30mg/2.0ml each
Synvisc-One (Hylan G-F 20) 48mg/10.0ml each
Refills, Directions, Quantity for each medication