



University Specialty Pharmacy
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Osteoarthritis Referral Form

Patient Name: (First) _____		(Last) _____	
Address: _____		City: _____	State: _____ Zip: _____
Home Ph: _____	Cell Ph: _____	Work Ph: _____	SS#: _____
Date of Birth: _____	Patient's Height: _____	Patient's Weight: _____	Male <input type="checkbox"/> Female <input type="checkbox"/>
Parent/Guardian if child: _____		Address: _____	
Primary Insurance: _____		Phone: () _____	PLEASE ATTACH COPY OF CARD!
Cardholder Name: _____	ID# _____	Group# _____	Employer: _____
Patient Drug Allergies: _____			

CLINICAL INFORMATION	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Other _____	Date of Diagnosis _____
Has patient received previous course of treatment with Hyaluronate Sodium? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long ago? _____ months			
Unilateral or Bilateral treatment? <input type="checkbox"/> Unilateral <input type="checkbox"/> Bilateral			
Is patient currently on other therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No What: _____			

PRESCRIPTION	
<input type="checkbox"/> Eflexxa® 20mg/2ml (PFS) <input type="checkbox"/> Hyalgan® 20mg/2ml (PFS) <input type="checkbox"/> Orthovisc® 30mg/2ml (PFS) <input type="checkbox"/> Supartz® 25mg/2.5ml (PFS) <input type="checkbox"/> Synvisc® 16mg/2ml (PFS) <input type="checkbox"/> Synvisc One™ 48mg/6ml (PFS)	
SIG: Inject contents of PreFilled Syringe Intra-Articularly Frequency: _____	
Dispense Quantity: _____ Refills: _____	
Other Instructions: _____	
Deliver Product to: <input type="checkbox"/> Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other: _____	
_____ Physician's Signature	_____ Date
Physician Name: _____	Address: _____
City: _____	State: _____ Zip: _____
Phone: _____	Fax: _____
DEA #: _____	License #: _____
NPI#: _____	State: _____
Office Contact: _____	Email: _____

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