Orchard Specialty
A DIVISION OF ORCHARD PHARMACEUTICAL SERVICES, INC.

Osteoarthritis Prescription and Enrollment Form

Phone: 877-437-9012 Fax: 877-309-0687

PATIENT INFORMATION

Patient Name: ____
Date of Birth: __________ Sex: ______ SS#____________________
Address: ____
City: __________________State:________Zip:________________
Home Phone: _____________ Work Phone: __________________
Cell Phone: ________________ E-mail:______________________
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: ______________________________
Insurance Company Phone: ______________________________
Policy holder:_______________________________________
Policy holder Employer:_________________________________
Relationship to Patient:_________________________________
ID# ___________________________Group#__________________
RxBIN: ___________________RxPCN:______________________

PRESCRIBER INFORMATION

Physician Name:______________________________________
Address:____
City: __________________State: ______________ Zip: __________
Phone#:_________________________Fax#:__________________
DEA#_______________________NPI#_______________________
License#:__________________Medicaid UPIN#:_______________
Physician Specialty: ___________________________________

☒ **Ship Product to: Physician or Clinic**

Office Contact: _______________________________________
Date Shipment Needed:____________
Shipment Address:______________________________________
____
City: __________________State: ______________Zip:___________

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

CLINICAL INFORMATION

Diagnosis:
☐715.16 Primary localized OA, lower leg
☐715.26 Secondary localized OA, lower leg
☐715.36 Localized OA, NOS, lower leg
☐719.46 pain in joint, lower leg
☐Other: ____

Patients Allergies: ____
Patient Height: _______________ Patient Weight: _______________

Previous/Current Therapies:
Acetaminophen/NSAID/COX-2 Inhibitors: ☐Current ☐Failed
Intra-articular corticosteroid injection: ☐Current ☐Failed
Physical Therapy: ☐ Current ☐Failed
Surgical Procedures (i.e. debridement, arthroscopy): ☐Current ☐ Failed

Has the patient had any sodium hyaluronate in the past? ☐ Yes ☐ No
If yes, what was the site of injection? ☐ Right Knee ☐ Left Knee ☐ Bilateral Knees
If yes, has it been less than 6 months since the last sodium hyaluronate injection for the SAME knee? ☐Yes ☐No
Date of Last Injection: ____________________

PRESCRIPTION INFORMATION

☐EUFLEXXA® (1% SODIUM HYALURONATE) 20MG/2ML PFS
☐HYALGAN® (SODIUM HYALURONATE) 20MG/2ML ***(Please select):*** ☐VIAL ☐PFS
☐ORTHOVISC® (SODIUM HYALURONATE) 30MG/2ML PFS
☐SUPARTZ® (SODIUM HYALURONATE) 25MG/2.5ML PFS
☐SYNVISC-ONE® (HYLAN G-F 20) 48MG/6ML PFS
☐SYNVISC® (HYLAN G-F 20) 16MG/2ML PFS

SIG: Inject intra-articular into ☐RIGHT ☐ LEFT ☐ BILATERAL Knee(s)
ONCE PER WEEK for a total of #____ injections by physician.

X ____
Physician Signature (no stamps) **Date**

If physician requests Brand Name only, DAW MUST be HANDWRITTEN in the following space provided: ☐

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtains instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Orchard Pharmaceutical Services, Inc. 050812