Giant Eagle Specialty Pharmacy

Phone: 1-844-259-1891
Fax: 1-877-645-4142

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#8991)
2500 Lovi Road
Freedom, PA 15042

OSTEOARTHRITIS ENROLLMENT FORM

Today's Date: _____

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**_____ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: _____ ☐ Male ☐ Female DOB:_____
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Best Phone Number: _____ Alternate Phone Number: _____
Height:_____ Weight: _____ ☐ kgs. or ☐ lbs. Recorded Date: _____
Caregiver: _____ Allergies: _____
Store Preference (address): _____
Emergency Contact Name: _____ Emergency Contact Phone #: _____

Insurance Information: Please fax copy of insurance card (front + back)

Medical Assessment

DIAGNOSIS

☐ Osteoarthritis ICD-10 _____ Date of Diagnosis: _____

PATIENT EVALUATION

Does patient have a complete collapse of the joint space or bone loss? ☐ Yes ☐ No
Does patient have skin diseases or infection in or around the affected joint? ☐ Yes ☐ No
If patient has tried simple analgesics, please name and include strength duration: _____
_____
Has patient received previous course of treatment with hyaluronidase? ☐ Yes ☐ No
If yes, how long ago? _____ months
Did patient experience pain relief? ☐ Yes ☐ No
Does patient have extensive inflammation with joint effusion or an inflammation flare? ☐ Yes ☐ No
Has patient been treated with simple analgesics in the past? ☐ Yes ☐ No
Unilateral or bilateral treatment? ☐ unilateral ☐ bilateral
Please specify joint(s) to be injected:_____
Concomitant medications: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ EUFLEXXA® Include one 20G 1.5" needle per syringe	☐ 20mg/2ml Prefilled Syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks ☐ Other:_____	_____	_____
☐ HYALGAN® Include one 20G 1.5" needle per syringe/vial	☐ 20mg/2ml Prefilled Syringe ☐ 20mg/2ml Vial	☐ Inject contents of prefilled syringe/vial intra-articularly once a week for _____ weeks ☐ Other:_____	_____	_____
☐ ORTHOVISC® Include one 20G 1.5" needle per syringe	☐ 30mg/2ml Syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for _____ weeks ☐ Other:_____	_____	_____
☐ SUPARTZ® Include one 23G 1.5" needle per syringe	☐ 25mg/2.5ml Prefilled Syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 5 weeks ☐ Other:_____	_____	_____
☐ SYNVISC-ONE™ Include one 20G 1.5" needle per syringe	☐ 48mg/6ml Prefilled Syringe	☐ Inject contents of prefilled syringe intra-articularly one time ☐ Other:_____	1 or 2	0
☐ SYNVISC® Include one 20G 1.5" needle per syringe	☐ 16mg/2ml Prefilled Syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks ☐ Other:_____	_____	_____
☐ GEL-ONE 30 Include one 20G 1.5" needle per syringe	☐ 30mg/3ml Prefilled Syringe	☐ Inject contents of prefilled syringe intra-articularly once	_____	_____
☐ MONOVISC Include one 20G 1.5" needle per syringe	☐ 88mg/5mL Prefilled Syringe	☐ Inject contents of one prefilled syringe intra-articularly once	_____	_____

Prescriber Information

Date Prescription Needed: _____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #:_____ NPI #: _____ Tax ID#: _____
Office Address: _____ City: _____ State: _____ ZIP: _____
State License #: _____ DEA #: _____

In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below. _____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: _____ **Date:** _____