OSTEOARTHRITIS SPECIALTY CARE PROGRAM

Phone: **856-963-4742** • Fax: **856-541-8580**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

❶ PATIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____

DOB: _____ Gender: ❍ M ❍ F Caregiver: _____

Height: _____ Weight: _____ Allergies: _____

❷ PRESCRIBER INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

NPI: _____ DEA: _____

Tax I.D.: _____

Office Contact: _____ Phone: _____

❸ STATEMENT OF MEDICAL NECESSITY:

Date of Diagnosis: _____ICD-10:_____

Select Diagnosis: ❑ Knee ❑ Hip ❑ Hand ❑ Other diagnosis

Signs of abnormal synovial fluid? ❑ Yes ❑ No

Erythrocyte sedimentation rate:_____

Prior trial with or contraindication to intra-articular corticosteroid therapy? ❑ Yes ❑ No

Does patient have any contraindication to requested therapy?
❑ Yes ❑ No

Is patient scheduled for knee replacement within the next 6 months?
❑ Yes ❑ No

Is the patient allergic to any avian proteins, feathers, or eggs
❑ Yes ❑ No

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment
Non-Pharmacologic:	
❑ Strength Training	_____
❑ Physical Therapy	_____
❑ Assisted Walking Devices	_____
❑ Diet Changes	_____
❑ Weight Loss	_____
Pharmacologic:	
❑ NSAID (Ibuprofen)	_____
❑ Acetaminophen (Tylenol)	_____
❑ Capsaicin (Topical Cream)	_____
❑ Topical Creams (Hydrocortisone)	_____
❑ Other:	_____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

❹ PRODUCT DELIVERY: ❍ MD Authorized Patient Pick Up Or Delivery ❍ Physician's Office

❺ INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ DUROLANE®	❑ 60 mg/3 mL prefilled syringe	❑ Inject 60 mg intra-articularly once weekly for 2 weeks	1 Syringe per carton	0
❑ MONOVISC®	❑ 88 mg/4 mL prefilled syringe	❑ Inject 88 mg intra-articularly as a one-time dose	1 Syringe per carton	0
❑ ORTHOVISC®	❑ 30 mg/2 mL prefilled syringe	❑ Inject 30 mg intra-articularly once weekly for 3-4 weeks	1 Syringe per carton	0
❑ SUPARTZ FX®	❑ 25 mg/ 2.5 mL prefilled syringe	❑ Inject 25 mg intra-articularly once weekly for 5 weeks	1 Syringe per carton	0
❑ SYNVISC-ONE®	❑ 48 mg/6 mL prefilled syringe	❑ Inject 48 mg intra-articularly as a one-time dose	1 Syringe per carton	0
❑ ZILRETTA®	❑ 32mg/5 mL prefilled syringe	❑ Inject 32 mg intra-articularly as a one-time dose	1 Syringe per Kit	0
❑ OTHER	_____	_____		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.