Osteoarthritis Enrollment Form

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NOBLE HEALTH SERVICES
A SPECIALTY PHARMACY

Signature Care Program

Delivery Need By: Delivery to: ☐ Patients Home ☐ Physician's Office ☐ Other

☐ **Noble Syracuse**
Phone: (888) 843-2040
Fax: (888) 842-3977
☐ **Noble Mississippi**
Phone: (866) 420-4041
Fax: (601) 420-4040

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐ Female ☐ Male	Prescriber Name:
Address:	Address:
City, State, Zip: , ,	City, State, Zip: , ,
Phone:	Phone:
Date of Birth:	Fax:
Social Security Number:	DEA/NPI#:

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ICD-10:	Has the patient been treated previously for this condition? ☐ Yes ☐ No
Height: feet inches Weight: lbs.	Medications failed:
Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication	Dosage/Strength	Directions	Quantity	Refills
EUFLEXXA	☐ 20 mg/2 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use ☐ unilaterally ☐ bilaterally. Supplies: Include one 20G 1.5" needle per syringe.	☐ Prefilled Syringe(s)	
GEL-ONE	☐ 30 mg/3 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly one time. Patient to use ☐ unilaterally ☐ bilaterally. Supplies: Include one 20G 1.5" needle per syringe.	☐ Prefilled Syringe(s)	
HYALGAN	☐ 20 mg/2 mL prefilled syringe ☐ 20 mg/2 mL vial	☐ Inject contents of prefilled syringe/vial intra-articularly once a week for 5 weeks. Patient to use ☐ unilaterally ☐ bilaterally. Supplies: Include one 20G 1.5" needle per syringe.	☐ Prefilled Syringe(s) ☐ Vials	
MONOVISC	☐ 88 mg/4 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly one time. Patient to use ☐ unilaterally ☐ bilaterally. Supplies: Include one 20G 1.5" needle per syringe.	☐ Prefilled Syringe(s	
ORTHOVISC	☐ 30 mg/2 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly once a week for ____ weeks. Patient to use ☐ unilaterally ☐ bilaterally. Supplies: Include one 20G 1.5" needle per syringe.	☐ Prefilled Syringe(s	
SUPARTZ	☐ 25 mg/2.5 mL prefilled syringe	☐ Inject contents of prefilled syringe/vial intra-articularly once a week for 5 weeks. Patient to use ☐ unilaterally ☐ bilaterally. Supplies: Include one 20G 1.5" needle per syringe.	☐ Prefilled Syringe(s	
SYNVISC	☐ 16 mg/2 mL prefilled syringe	☐ Inject contents of prefilled syringe/vial intra-articularly once a week for 3 weeks. Patient to use ☐ unilaterally ☐ bilaterally. Supplies: Include one 20G 1.5" needle per syringe.	☐ Prefilled Syringe(s	
SYNVISC ONE	☐ 48 mg/6 mL prefilled syringe	☐ Inject contents of prefilled syringe intra-articularly one time. Patient to use ☐ unilaterally ☐ bilaterally. Supplies: Include one 20G 1.5" needle per syringe.	☐ Prefilled Syringe(s	
Other:				

☐ Patient is interested in patient support programs

Ancillary supplies provided for administration

Office Contact Name: _____ Preferred Phone Number & Extension: _____

Physician Signature: _____ Date: _____

E-Scribe Rx and Fax this Form