BLUEGRASS PHARMACY | OSTEOARTHRITIS ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

◯ M15.Ø Primary (osteo)arthritis
◯ Other:

Height (in/cm): Weight (lb/kg):

Allergies:

Current Medications:

Has patient received injection training? ◯ Yes ◯ No

Specialty pharmacy to coordinate home health nursing visit as necessary: ◯ Yes ◯ No

Agency of choice:

◯ Home health nursing coordination is not necessary
Reason: ◯ MD office administered ◯ Home health nursing already coordinated

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Euflexxa	◯ 20 mg/2 ml PFS	◯ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. ◯ Other:		
◯ Gel-One	◯ 30 mg/3 ml PFS	◯ Inject contents of prefilled syringe intra-articularly one time. ◯ Other:	1	0
◯ GELSYN-3	◯ 16.8mg/2ml PFS	◯ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks		
◯ Hyalgan	◯ 20 mg/2 ml PFS ◯ 20 mg/2ml vial	◯ Inject contents of vial/prefilled syringe intra-articularly once a week for ____ weeks. ◯ Other:		
◯ Monovisc	◯ 88mg/4ml PFS	◯ Inject the contents of prefilled syringe intra-articularly one time		
◯ Orthovisc	◯ 30 mg/2 ml syringe	◯ Inject contents of vial/prefilled syringe intra-articularly once a week for ____ weeks. ◯ Other:		
◯ Supartz FX	◯ 25 mg/2.5 ml PFS	◯ Inject contents of prefilled syringe intra-articularly once a week for 5 weeks. ◯ Other:		
◯ Synvisc	◯ 16 mg/2 ml PFS	◯ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. ◯ Other:		
◯ Synvisc One	◯ 48 mg/6 ml PFS	◯ Inject contents of prefilled syringe intra-articularly one time. ◯ Other:	1	0

◯ Include one 23G (for Supartz) or 20G (for all other listed drugs) 1.5" needle per syringe

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE