aleracare
advanced specialty pharmacy

Osteoarthritis
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Clinical Assessment: Please fax recent clinical notes, labs and tests to expedite the Prior Authorization Process

ICD-10 Codes: ◯ M19.0 Primary osteoarthritis of other joints

◯ Other ICD-10 Code(s): _____ (please specify)

Medication	Dose/Strength	Directions for Use	Qty	Refills
◯ **EUFLEXXA®**	◯ 20mg/2ml prefilled syringe	◯ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks ◯ Other		
◯ **GEL-ONE®**	◯ 0.3mg Prefilled Syringe	◯ Inject contents of prefilled syringe intra-articularly one time ◯ Other		
◯ **HYALGAN®**	◯ 20mg/2ml prefilled syringe	◯ Inject contents of prefilled syringe/vial intra-articularly ones a week for _____ weeks ◯ Other		
◯ **ORTHOVISC®**	◯ 30mg/2ml prefilled syringe ◯ Other	◯ Inject contents of prefilled syringe/vial intra-articularly once a week for _____ weeks ◯ Other		
◯ **SUPARTZ®**	◯ 25mg/2.5 ml prefilled syringe ◯ Other	◯ Inject contents of prefilled syringe/vial intra-articularly once a week for _____ weeks ◯ Other		
◯ **SYNVISC ONE®**	◯ 48 mg/6ml prefilled syringe	◯ Inject contents of prefilled syringe intra-articularly 1 one time ◯ Other		
◯ **SYNVISC®**	◯ 16mg/2ml prefilled syringe	◯ Inject contents of prefilled syringe intra-articularly once a week for 3 weeks ◯ Other		

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature _____ **Date** _____