Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Twin Oaks Specialty Pharmacy

Fax: 855-909-TOSP (8677)

OSTEOARTHRITIS ENROLLMENT FORM

Date Medication Needed: ______________ Ship To: Patient's Home Prescriber's Office Pick-up: Injection training by pharmacy?

1: Patient Information: Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Patient Name: ______________________ Birthdate: ____________ Sex: Male Female Height: ________ Weight: ________ lbs. kg.

Soc. Sec. #: ______________ Preferred Phone: ______________ Known Allergies: ______________________

Address: ______________________ City: ______________ State: ________ Zip: ________

Alternate Caregiver Name: ______________________ Preferred Phone: ______________________

2: Prescriber Information

Provider Name: ______________________ DEA#: ____________ NPI#: ____________ Tax ID#: ____________

Address: ______________________ Phone: ______________ Fax: ______________

City, State, Zip: ______________________ Key Contact: ______________ Phone: ______________

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Prior Failed Medication(s):	Length of Treatment	Reason for Discontinuing
	____/____/______-____/____/______	
	____/____/______-____/____/______	
	____/____/______-____/____/______	

Date of Diagnosis: _____/_____/_______

M15.0 Osteoarthritis generalized

M19.90 Osteoarthritis localized primary

M19.91 Osteoarthritis localized secondary

Other: ______________________

Last X-Ray Date: _____/_____/_______

Any changes with the latest X-Ray?

Yes

No

Comments:

PRESCRIPTION

☐ New ☐ Refill Ship by: ____/____/____ SHIP TO: ☐ Patient's Home ☐ Doctor's Office ☐ Other: ____________________

Drug		Directions & Quantity	Refills
Euflexxa®	Pre-filled Syringe	Inject 2ml IA into affected knee(s) at weekly intervals for 3 weeks. Bilateral knees (Quantity: 6) Left knee (Quantity: 3) Right knee (Quantity: 3)	
Hyalgan®	Pre-filled Syringe Vials	Inject 2ml IA into affected knee(s) at weekly intervals for 5 weeks. Bilateral knees (Quantity: 10) Left knee (Quantity: 5) Right knee (Quantity: 5)	
Orthovisc®	Pre-filled Syringe	Inject 2ml IA into affected knee(s) at weekly intervals for 3 weeks. Bilateral knees (Quantity: 6) Left knee (Quantity: 3) Right knee (Quantity: 3) Inject 2ml IA into affected knee(s) at weekly intervals for 4 weeks. Bilateral knees (Quantity: 8) Left knee (Quantity: 4) Right knee (Quantity: 4)	
Supartz FX®	Pre-filled Syringe	Inject 2.5ml IA into affected knee(s) at weekly intervals for 3 weeks. Bilateral knees (Quantity: 6) Left knee (Quantity: 3) Right knee (Quantity: 3) Inject 2.5ml IA into affected knee(s) at weekly intervals for 5 weeks. Bilateral knees (Quantity: 10) Left knee (Quantity: 5) Right knee (Quantity: 5)	
Synvisc®	Pre-filled Syringe	Inject 2ml IA into affected knee(s) at weekly intervals for 3 weeks. Bilateral knees (Quantity: 6) Left knee (Quantity: 3) Right knee (Quantity: 3)	
Synvisc-One®	Pre-filled Syringe	Inject 6ml IA into affected knee(s) as directed. Bilateral knees (Quantity: 2) Left knee (Quantity: 1) Right knee (Quantity: 1)	

Patient: By signing this form, patient agrees to release his/her PHI to Twin Oaks Specialty Pharmacy for the purpose of medical and pharmaceutical treatment as per HIPAA compliance and to enroll in the pharmaceutical company assisted patient support programs. Patient Signature: Date:

Prescriber Signature: By signing this form, and utilizing our services, you are also authorizing Twin Oak Specialty Pharmacy to serve as your designated agent in dealing with medical and prescription insurance companies and co-pay assistance foundations.

Dispense as written Date Substitution Permissable Date:

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.