Osteoarthritis Referral Form

CALIFORNIA SPECIALTY™ PHARMACY

Physicians must fax the completed referral form to California Specialty Pharmacy at 866-853-6555

Your CSP Rep: _____ and Tel: _____

PATIENT INFORMATION:	PHYSICIAN INFORMATION: Ship to: ☐Physician's Office ☐Patient's Home
Patient Name: _____	Physician Name: _____
Address: : _____	State LIC # _____ DEA # _____NPI # _____
City: _____ State: _____ Zip:_____	Address: _____
Home Phone: _____Cell Phone: : _____	City: _____ State: _____ Zip: _____
Patient Soc. Sec #: _____	Phone: _____ Fax: _____
Date of Birth: _____ Sex: ☐ Male ☐ Female	Nurse/Key Office Contact: _____
Weight: _____ ☐ lbs ☐ kg Height:_____ BSA:_____	

INSURANCE INFORMATION:

☐ Demographic sheet ☐ Universal claim form ☐ Insurance cards

*Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)

DIAGNOSTIC INFORMATION:

☐ Osteoarthritis ICD-9CM 715.0. ☐ Other Diagnosis: _____

- Has patient been treated previously for this condition? ☐ Yes ☐ No Medication(s) failed:_____
- Is patient currently on therapy? ☐ Yes ☐ No Type /medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No If yes, How long should patient wait before starting the new medication?
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

_____

PRESCRIPTION:

MEDICATION & DIRECTIONS	Quantity	REFILL
☐ **Euflexxa®** 20mg/2ml prefilled syringes ☐ *Inject 2ml IA into affected knee(s) at weekly intervals.* ☐ Bilateral Knees ☐ Left Knee ☐ Right Knee	☐ 3 week supply	_____
☐ **Gel one®** 30 mg/3 mL prefilled syringes ☐ *Inject 3 mL IA into affected knee(s) once .* ☐ Bilateral Knees ☐ Left Knee ☐ Right Knee	☐ ___ Week Supply	_____
☐ **Gelsyn-3** 16.8 mg/2 mL ☐ *Inject 2 mL IA into affected knee(s) one time for 3 weeks.* ☐ Bilateral Knees ☐ Left Knee ☐ Right Knee	☐ 3 week supply	_____
☐ **Hyalgan®** 20mg/2ml prefilled syringes ☐ *Inject 2ml IA into affected knee(s) at weekly intervals for 3 weeks* ☐ Bilateral ☐ Left Knee ☐ Right Knee	☐ 3 week supply	_____
☐ **Hymovis®** 24 mg/3 mL (ADD) ☐ *Inject 3 mL IA into affected knee(s) once a week for 2 weeks.* ☐ Bilateral Knees ☐ Left Knee ☐ Right Knee	☐ 2 week supply	_____
☐ **Monovisc®** 88 mg/4 mL prefilled syringes ☐ *Inject 4 mL IA into affected knee (s) once.* ☐ Bilateral Knees ☐ Left Knee ☐ Right Knee	☐ 1 week supply ☐ 2 week supply	_____
☐ **Orthovisc®** 30mg/2ml ☐ *Inject 2ml IA into affected knee(s) one time for 3 weeks* ☐ Bilateral ☐ Left Knee ☐ Right Knee	☐ 3 week supply	_____
☐ **Supartz®** 25mg/2.5ml prefilled syringes ☐ *Inject 2ml IA into affected knee(s) one time for 3 weeks* ☐ Bilateral ☐ Left Knee ☐ Right Knee	☐ 3 week supply	_____
☐ **Synvisc One™** 48mg/6ml prefilled syringes ☐ *Inject 6ml IA into affected knee(s) one time for 3 weeks* ☐ Bilateral ☐ Left Knee ☐ Right Knee	☐ 3 week supply	_____
☐ **Synvisc** 16mg/2ml prefilled syringes ☐ *Inject 2ml IA into affected knee(s) one time for 3 weeks* ☐ Bilateral ☐ Left Knee ☐ Right Knee	☐ 3 week supply	_____
☐ **Zilretta** 32 mg ☐ *Inject 32 mg IA into affected knee(s) once* ☐ Bilateral ☐ Left Knee ☐ Right Knee		_____
☐ **Others**		_____

Prescriber Signature Required ****Prescription is void if the number of drugs prescribed is not noted***

I authorize California Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

PRESCRIBER SIGNATURE	NO. OF DRUGS PRESCRIBED _____	DATE
	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	