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OSTEOARTHRITIS ENROLLMENT FORM

Today's Date: _____
 Needed By: _____

Last update 7.15.2018



www.commcarepharmacy.com
 Plantation, FL
 Phone: 888.203.7973
 Fax: 888.203.7980
 NCPDP: 1079638
 NPI: 1598762015

Patient Demographics: (Please provide the following or attach demographics sheet) Patient Name: _____ Address: _____ City, State, Zip: _____ Preferred Phone: _____ Alt. Phone: _____ Last four digits of SS#: _____ Date of Birth: _____ Gender: _____ Allergies: _____ Height: _____ Weight: _____	Provider Office: (Please provide as much information as possible) Prescriber's Name: _____ Group/Hospital: _____ Specialty: _____ License#: _____ Tax ID#: _____ Address: _____ NPI: _____ DEA: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____
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Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Primary Insurance: Name of Insurer: _____ ID#: _____ BIN#: _____ PCN#: _____ Group#: _____ Phone: _____
Secondary Insurance: Name of Insurer: _____ ID#: _____ BIN#: _____ PCN#: _____ Group#: _____ Phone: _____

Medication Delivery to: (choose one) Always to Physicians Office Other: _____

Diagnostic Information: Diagnosis (Please provide ICD-10-CM codes) _____ _____ _____ _____

Date if diagnosis: _____ OR Years with disease: _____ Affected Joint(s): Right Knee Left Knee Both Knees

Previous therapies: _____

Drug Name	Strength/Formulation	Directions	Quantity	Refills
<input type="checkbox"/> Durolane®	60mg/3mL Prefilled Syringe	<input type="checkbox"/> Inject 3mL into the intra-articular space one time Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> 1 Syringe <input type="checkbox"/> 2 Syringes	
<input type="checkbox"/> Euflexxa®	20mg/2mL Prefilled Syringe	<input type="checkbox"/> Inject 2mL into the intra-articular space weekly for 3 weeks Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> 3 Syringe <input type="checkbox"/> 6 Syringes	
<input type="checkbox"/> Gel-One®	30mg/3mL Prefilled Syringe	<input type="checkbox"/> Inject 3mL into the intra-articular space one time Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> 1 Syringe <input type="checkbox"/> 2 Syringes	
<input type="checkbox"/> Gelsyn-3™	16.8mg/2mL Prefilled Syringe	<input type="checkbox"/> Inject 2mL into the intra-articular space weekly for 3 weeks Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> 3 Syringe <input type="checkbox"/> 6 Syringes	
<input type="checkbox"/> Genvisc 850®	25mg/2.5ml Prefilled Syringe	<input type="checkbox"/> Inject 2.5mL into the intra-articular space weekly for __ weeks Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> __ Syringes	
<input type="checkbox"/> Hyalgan®	<input type="checkbox"/> 20mg/2mL Prefilled Syringe <input type="checkbox"/> 20mg/2ml Vial	<input type="checkbox"/> Inject 2mL into the intra-articular space weekly for __ weeks Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> __ Syringes <input type="checkbox"/> __ Vials	
<input type="checkbox"/> Hymovis®	24mg/3mL Prefilled Syringe	<input type="checkbox"/> Inject 3mL into the intra-articular space initially and one week after the first injection. Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> __ Syringes <input type="checkbox"/> __ Vials	
<input type="checkbox"/> Monovisc®	88mg/4mL Prefilled Syringe	<input type="checkbox"/> Inject 4mL into the intra-articular space one time Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> 1 Syringe <input type="checkbox"/> 2 Syringes	
<input type="checkbox"/> Orthovisc®	30mg/2mL Prefilled Syringe	<input type="checkbox"/> Inject 2mL into the intra-articular space weekly for __ weeks Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> __ Syringes	
<input type="checkbox"/> SupartzFX™	25mg/2.5mL Prefilled Syringe	<input type="checkbox"/> Inject 2.5mL into the intra-articular space weekly for __ weeks Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> __ Syringes	
<input type="checkbox"/> Synvisc®	16mg/2mL Prefilled Syringe	<input type="checkbox"/> Inject 2mL into the intra-articular space weekly for 3 weeks Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> 3 Syringe <input type="checkbox"/> 6 Syringes	
<input type="checkbox"/> Synvisc-One®	48mg/6mL Prefilled Syringe	<input type="checkbox"/> Inject 6mL into the intra-articular space one time Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> 1 Syringe <input type="checkbox"/> 2 Syringes	
<input type="checkbox"/> Visco-3™	25mg/2.5mL Prefilled Syringe	<input type="checkbox"/> Inject 2.5mL into the intra-articular space weekly for __ weeks Inject into <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both Knees	<input type="checkbox"/> 3 Syringe <input type="checkbox"/> 6 Syringes	
<input type="checkbox"/> Other				

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to Acro Commcare

Physician Signature: _____ DAW (Dispense as Written) **Date:** _____

Patient Support Programs: I authorize Acro Pharmaceutical Services and Commcare Specialty Pharmacy to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

*Patient Signature: (required for participation) _____ Date: _____ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program

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