ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

Sharon Hill, PA
Phone: 800.906.7798
Fax: 877.381.3806
NCPDP: 3982902
NPI: 1639103823

Memphis, TN
Phone: 800.906.7798
Fax: 844.612.9057
NCPDP: 4447783
NPI: 1518349562

OSTEOARTHRITIS ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 7.15.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

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:_____

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
□Durolane®	60mg/3mL Prefilled Syringe	□Inject 3mL into the intra-articular space one time Inject into □R □L □Both Knees	□1 Syringe □2 Syringes	
□Euflexxa®	20mg/2mL Prefilled Syringe	□Inject 2mL into the intra-articular space weekly for 3 weeks Inject into □R □L □Both Knees	□3 Syringe □6 Syringes	
□Gel-One®	30mg/3mL Prefilled Syringe	□Inject 3mL into the intra-articular space one time Inject into □R □L □Both Knees	□1 Syringe □2 Syringes	
□Gelsyn-3™	16.8mg/2mL Prefilled Syringe	□Inject 2mL into the intra-articular space weekly for 3 weeks Inject into □R □L □Both Knees	□3 Syringe □6 Syringes	
□Genvisc 850®	25mg/2.5ml Prefilled Syringe	□Inject 2.5mL into the intra-articular space weekly for__**weeks** Inject into □R □L □Both Knees	□___Syringes	
□Hyalgan®	□20mg/2mL Prefilled Syringe □20mg/2ml Vial	□Inject 2mL into the intra-articular space weekly for ___**weeks** Inject into □R □L □Both Knees	□___Syringes □____Vials	
□Hymovis®	24mg/3mL Prefilled Syringe	□Inject 3mL into the intra-articular space initially and one week after the first injection. Inject into □R □L □Both Knees	□___Syringes □____Vials	
□Monovisc®	88mg/4mL Prefilled Syringe	□Inject 4mL into the intra-articular space one time Inject into □R □L □Both Knees	□1 Syringe □2 Syringes	
□Orthovisc®	30mg/2mL Prefilled Syringe	□Inject 2mL into the intra-articular space weekly for ___**weeks** Inject into □R □L □Both Knees	□___Syringes	
□SupartzFX™	25mg/2.5mL Prefilled Syringe	□Inject 2.5mL into the intra-articular space weekly for__**weeks** Inject into □R □L □Both Knees	□___Syringes	
□Synvisc®	16mg/2mL Prefilled Syringe	□Inject 2mL into the intra-articular space weekly for 3 weeks Inject into □R □L □Both Knees	□3 Syringe □6 Syringes	
□Synvisc-One®	48mg/6mL Prefilled Syringe	□Inject 6mL into the intra-articular space one time Inject into □R □L □Both Knees	□1 Syringe □2 Syringes	
□Visco-3™	25mg/2.5mL Prefilled Syringe	□Inject 2.5mL into the intra-articular space weekly for__**weeks** Inject into □R □L □Both Knees	□3 Syringe □6 Syringes	
□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