Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.

SENDERRA
Specialty Pharmacy
1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081
This prescription form is to be sent & received via fax

Osteoarthritis Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

Prescribing Practitioner:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Office:	Fax:
Contact:	

PATIENT INFORMATION

Name: ☐ M ☐ F		DOB: ___/___/_____	SS#: ___-___-_____
Street:	City:	State:	ZIP:
Tel:	Alt. Tel:	☐ English ☐ Spanish ☐ Other: _____	Wt.: _____ Ht.: _____

PRESCRIPTION

Has the patient received a loading dose/starter kit? ☐**Yes Start Date:** ___/___/_____ ☐**No** **SHIP TO:** ☐**Patient's Home** ☐**Doctor's Office** ☐**Other:** _____

Drug		Directions & Quantity	Refills
Euflexxa®	☐ Pre-filled Syringe	☐ Inject 2 mL IA **into each knee** at weekly intervals for 3 weeks (Quantity: 6) ☐ Inject 2 mL IA into ☐**Left knee** OR ☐**Right knee** at weekly intervals for 3 weeks (Quantity: 3)	
Gel-One®	☐ Pre-filled Syringe	☐ Inject 3 mL IA **into each knee** as directed (Quantity: 2) ☐ Inject 3 mL IA into ☐**Left knee** OR ☐**Right knee** as directed (Quantity: 1)	
Hyalgan®	☐ Pre-filled Syringe ☐ Vials	☐ Inject 2 mL IA **into each knee** at weekly intervals for 5 weeks (Quantity: 10) ☐ Inject 2 mL IA into ☐**Left knee** OR ☐**Right knee** at weekly intervals for 5 weeks (Quantity: 5)	
Hymovis®	☐ Pre-filled Syringe	☐ Inject 3 mL IA **into each knee** at day 0 and day 7 (Quantity: 4) ☐ Inject 3 mL IA into ☐**Left knee** OR ☐**Right knee** at day 0 and day 7 (Quantity: 2)	
Orthovisc®	☐ Pre-filled Syringe	☐ Inject 2 mL IA **into each knee** at weekly intervals for **3 weeks** (Quantity: 6) ☐ Inject 2 mL IA into ☐**Left knee** OR ☐**Right knee** at weekly intervals for **3 weeks** (Quantity: 3) ☐ Inject 2 mL IA **into each knee** at weekly intervals for **4 weeks** (Quantity: 8) ☐ Inject 2 mL IA into ☐**Left knee** OR ☐ **Right knee** at weekly intervals for **4 weeks** (Quantity: 4)	
Supartz FX®	☐ Pre-filled Syringe	☐ Inject 2.5 mL IA **into each knee** at weekly intervals for **3 weeks** (Quantity: 6) ☐ Inject 2.5 mL IA into ☐**Left knee** OR ☐**Right knee** at weekly intervals for **3 weeks** (Quantity: 3) ☐ Inject 2.5 mL IA **into each knee** at weekly intervals for **5 weeks** (Quantity: 10) ☐ Inject 2.5 mL IA into ☐**Left knee** OR ☐ **Right knee** at weekly intervals for **5 weeks** (Quantity: 5)	
Synvisc®	☐ Pre-filled Syringe	☐ Inject 2 mL IA **into each knee** at weekly intervals for 3 weeks (Quantity: 6) ☐ Inject 2 mL IA into ☐**Left knee** OR ☐ **Right knee** at weekly intervals for 3 weeks (Quantity: 3)	
Synvisc-One®	☐ Pre-filled Syringe	☐ Inject 6 mL IA **into each knee** as directed (Quantity: 2) ☐ Inject 6 mL IA into ☐**Left knee** OR ☐ **Right knee** as directed (Quantity: 1)	

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY*****

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____

☐ M15.0 Primary generalized osteoarthritis
☐ M17.9 Osteoarthritis of knee, unspecified
☐ M19.90 Unspecified osteoarthritis, unspecified site
☐ M19.91 Primary osteoarthritis, unspecified site
☐ Other: _____

Date of Diagnosis: ___/___/_____ **Allergies:** _____

Last x-ray date: ___/___/_____ Any changes with latest x-ray? ☐ Yes ☐ No

Additional Clinical Information:

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Senderra to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Senderra to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: **Date**: ___/___/_____

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should 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.