


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.

 <p><b>Osteoarthritis Enrollment Form</b></p> <p><b>Physician Offices Call: 855-460-7928</b></p> <p><b>Fax: 888-777-5645</b></p> <p>1301 E. Arapaho Rd., Ste. 101 Richardson, TX 75081</p> <p><i>This prescription form is to be sent &amp; received via fax</i></p>	Prescribing Practitioner:	
	NPI:	
	Tax ID:	
	Address:	
	Office:	Fax:
	Contact:	

PATIENT INFORMATION					
Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB: ____/____/____	SS#:	____-____-____	
Tel:	Al. Tel:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Wt.: _____	Ht.: _____	
Street:	City:	State:	ZIP:		

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

<b>Date of Diagnosis:</b> ____/____/____ M15.0 Osteoarthritis generalized M19.90 Osteoarthritis localized primary M19.91 Osteoarthritis localized secondary Other: _____	<b>Last X-Ray Date:</b> ____/____/____  <b>Any changes with the latest X-Ray?</b> Yes No	<b>Allergies:</b>  
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**\*\*\*PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY LAB NOTES REGARDING THERAPY\*\*\***

PRESCRIPTION		
<input type="checkbox"/> New <input type="checkbox"/> Refill	Ship by: ____/____/____	SHIP TO: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> 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)	

INJECTION TRAINING		
Patient has received pen and injection training	Physician's office to provide injection training	Senderra Rx to coordinate injection training

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

<b>Prescribing Practitioner:</b> _____	<b>Date:</b> ____/____/____
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**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.