HAWAII SPECIALTY™ PHARMACY

Osteoarthritis Referral Form

Please complete and attach to MDX prior Authorization form

MDX Hawai'i

PATIENT INFORMATION:	PHYSICIAN INFORMATION:
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	ALTERNATE DOSING	QTY	REFILL
☐ **Euflexxa** 20mg/2ml prefilled syringes ☐ 3 prefilled syringes ☐ 6 prefilled syringes			
Inject 2ml IA into affected knee(s) at weekly intervals. ☐ Bilateral Knees ☐ Left Knee ☐ Right Knee			
☐ **Hyalgan** 20mg/2ml prefilled syringes ☐ 3 prefilled syringes ☐ 6 prefilled syringes			
Inject 2ml IA into affected knee(s) at weekly intervals for 3 weeks ☐ Bilateral Knees ☐ Left Knee ☐ Right Knee			
☐ **Orthovisc** 30mg/2ml ☐ 1 prefilled syringe ☐ 2 prefilled syringes			
Inject 2ml IA into affected knee(s) one time for 3 weeks ☐ Bilateral ☐ Left Knee ☐ Right Knee			
☐ **Supartz** 25mg/2.5ml prefilled syringes			
Inject 2ml IA into affected knee(s) one time for 3 weeks ☐ Bilateral ☐ Left Knee ☐ Right Knee			
☐ **Synvisc One™** 48mg/6ml prefilled syringes			
Inject 2ml IA into affected knee(s) one time for 3 weeks ☐ Bilateral ☐ Left Knee ☐ Right Knee			
☐ **Synvisc** 16mg/2ml prefilled syringes			
Inject 2ml IA into affected knee(s) one time for 3 weeks ☐ Bilateral ☐ Left Knee ☐ Right Knee			
☐ Others			

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

I authorize Hawaii 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	

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