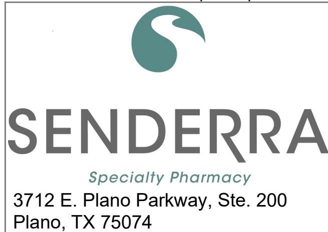
Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.



3712 E. Plano Parkway, Ste. 200
Plano, TX 75074

This prescription form is to be sent & received via fax

Osteoarthritis Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ___/___/______	SS#: _____-_____-_________
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ 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
Durolane®	☐ 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)	
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)	
Gelsyn-3®	☐ 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)	
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)	
Visco-3™	☐ 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)	

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
☐ M17.11 Unilateral primary osteoarthritis, right knee
☐ M17.12 Unilateral primary osteoarthritis, left knee
☐ 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:

PRESCRIBER SIGNATURE

To Prescriber: 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.

Prescriber: **Date**: ___/___/______

CONFIDENTIALITY NOTICE

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