Pharmax SPECIALTY PHARMACY

OSTEOARTHRITIS REFERRAL FORM

TEL 813.880.2500
FAX 813.880.2501
TOLL FREE 1.866.880.2507

PATIENT INFORMATION

Name:_____ Address:_____ _____ _____ Phone:_____

SSN:_____ DOB:_____ Sex:_____

Weight:_____ Height:_____ Allergies:_____ Ship to: ☐ Patient ☐ Clinic

INSURANCE

Prescription Card: _____ Name of Insurer:_____ ID#_____ BIN:_____ PCN:_____

Group:_____ (Please attach copies of insurance cards.)

DIAGNOSIS

☐ICD-10:_____ Diagnosis:_____

☐715.0 Osteoarthritis, Affected Joints:_____ Prior Therapies: _____

Current Medications:_____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refill
☐ Euflexxa				
☐ Hyalgan				
☐ Orthovisc				
☐ Supartz				
☐ Synvisc				
☐ Synvisc One				
☐ Other				

PRESCRIBER INFORMATION

Physician Name:_____ Address:_____

State License#:_____ NPI:_____ DEA:_____

Phone #:_____ Fax #:_____ Office Contact Name /Number:_____

Prescriber's Signature:_____ Date:_____

I authorize pharmax specialty pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.