OSTEOARTHRITIS REFERRAL FORM

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment			Therapy Start Date
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty:	Date Provided:	Patient Height (cm/in): Weight (kg/lbs):	Date Obtained:
Other/Concomitant Medications (please list)			
Allergies ☐ NKDA ☐ Drug Allergies (please list)			
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)			

ICD-10 Code

☐ M17.0 Bilateral primary OA of knee
☐ M17 OA of Knee
☐ M17.10 Unilateral primary OA, unspecified knee
☐ M17.1 Unilateral primary OA of knee
☐ M17.11 Unilateral primary OA, right knee
☐ M17.12 Unilateral primary OA, left knee
☐ M17.9 OA of knee, unspecified
☐ Other _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

To be injected: ☐ Left Knee ☐ Right Knee ☐ Bilaterally

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ DUROLANE®	60 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time.		
☐ Euflexxa®	20 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks.		
☐ GELSYN-3	16.8 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks.		
☐ Gel-One®	30 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time.		
☐ GenVisc® 850	25 mg/2.5 mL prefilled syringe	Inject contents of prefilled syringe/vial intra-articularly once a week for 5 weeks.		
☐ Hyalgan®	☐ 20 mg/2 mL prefilled syringe ☐ 20 mg/2 mL vial	Inject contents of prefilled syringe/vial intra-articularly once a week for 5 weeks.		
☐ Hymovis®	24 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 2 weeks.		
☐ Monovisc®	88 mg/4 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time.		
☐ Orthovisc®	30 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for _____ weeks.		
☐ Sodium Hyaluronate	20 mg/2 ml prefilled syringe	Inject contents of one prefilled syringe intra-articularly once weekly for 3 weeks.		
☐ Supartz FX	25 mg/2.5 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 5 weeks.		
☐ Synvisc®	16 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks.		
☐ Synvisc-One®	48 mg/6 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time.		
☐ Triluron	☐ 20 mg/2 mL prefilled syringe ☐ 20 mg/2 ml vial	Inject contents of one prefilled syringe or vial once weekly for 3 weeks.		
☐ TriVisc	25 mg/2.5 mL prefilled syringe	Inject contents of one prefilled syringe intra-articularly once weekly for 3 weeks.		
☐ Visco-3	25 mg/2.5 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks.		
☐ Other _____				

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

REV1221