Osteoarthritis Enrollment Form Medications A-G

(Durolane, Euflexxa, Gel-One, Gelsyn-3)



Fax Referral To: 1-877-232-5455 Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813 Phone: 1-808-254-2727 NCPDP: 1203417

PATIENT INF		Six Simple Steps to Submitting a Referral				
-	ORMATION (Compl	lete or include demographic sheet)				
Patient Name:		DOB: Gend	ler: 🗌 Male 🗌 Female			
Address:		City, State, ZIP Code:				
		primary # provided below) 🗌 Text (to cell # provided below) 🗌 Email (
		the phone number(s) and email address above, you are consenting to receive				
-		out your prescription(s), account, and health care. Standard data rates apply. I	Message frequency varies.			
		Pharmacy will attempt to contact by phone.				
		Alternate Phone:				
	nail: Last Four of SSN: Primary Language: Irent/Caregiver/Legal Guardian Name (Last, First): Relationship to patient :					
		(Last, First):				
	R INFORMATION					
Prescriber's Name	e:	State License #:				
		Group or Hospital:				
Address:		City, State, ZIP Code: Contact Person: Contact's P				
		ase fax copy of prescription and insurance cards with this form, if available (front and ba	ack)			
4 DIAGNOSIS	AND CLINICAL IN	FORMATION				
Needs by Date:	Ship to	p: 🗌 Patient 🗌 Office 🗌 Other:				
Diagnosis (ICD-10						
M17.0 Bilatera	l primary OA of knee	🗌 M17.10 Unilateral primary OA, unspecified knee				
🗌 M17.11 Unilater	al primary OA, right kne	ee 🛛 M17.12 Unilateral primary OA, left knee				
🗌 M17.2 Bilateral	l post-traumatic OA of k	nee M17.30 Unilateral post-traumatic OA, unspecified kne	e			
M17.31 Unilate	ral post-traumatic OA, r	ight knee 🔲 M17.32 Unilateral post-traumatic OA, left knee				
M17.4 Other bi	ilateral secondary OA of	f knee 🛛 M17.5 Other unilateral secondary OA of knee				
	nee, unspecified	Other Code: Description	_			
	-	Other Code: Description	_			
Patient Clinical Ir	-	Other Code: Description Weight:lb/kg Height:				
Patient Clinical In Allergies:	-	Weight:lb/kg Height:				
Patient Clinical In Allergies:	nformation: ION INFORMATION	Weight:lb/kg Height:				
Patient Clinical In Allergies: 5 PRESCRIPTI MEDICATION	nformation: ION INFORMATION	Weight:lb/kg Height: N	in/cm QUANTITY/REFILLS Quantity:			
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The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Medications G-Z Osteoarthritis Enrollment Form

(GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz FX, SynoJoynt, Synvisc, Synvisc-One, TriVisc, Visco-3)

Patient Name:	Pleas	e Complete Patient and Prescriber InformationPatient DOB:Patient Phone:Patient Phone:PatientPhone:	
Prescriber Name:		Patient DOBPatient Phone:Patient Phone	
	ON INFORMATION		
MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILI
🗌 GenVisc 850	25 mg/3 mL prefilled syringe	Inject contents of prefilled syringe/vial intra-articularly once a week for 5 weeks. Patient to use: unilaterally bilaterally. Supplies: Include one 23G 1.5" needle per syringe.	Quantity: Refills:
🗌 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. Patient to use: unilaterally bilaterally. Supplies: Include one 20G 1.5" needle per syringe.	Quantity: Refills:
Hymovis	24 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 2 weeks. Patient to use: unilaterally bilaterally. Supplies: Include one 20G 1.5" needle per syringe.	Quantity: Refills:
Monovisc 🗌	88 mg/4 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: unilaterally bilaterally.	Quantity: Refills:
Orthovisc	30 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for weeks. Patient to use: unilaterally bilaterally. Supplies: Include one 20G 1.5" needle per syringe.	Quantity: Refills:
Supartz FX	25 mg/2.5 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 5 weeks. Patient to use: unilaterally bilaterally. Supplies: Include one 23G 1.5" needle per syringe.	Quantity: Refills:
SynoJoynt	20 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use: unilaterally bilaterally	Quantity: Refills:
Synvisc Synvisc	16 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use: unilaterally bilaterally. Supplies: Include one 20G 1.5" needle per syringe	Quantity: Refills:
Synvisc-One	48 mg/6 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: unilaterally bilaterally. Supplies: Include one 20G 1.5" needle per syringe	Quantity: Refills:
TriVisc	25mg/3mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: unilaterally bilaterally.	Quantity: Refills:
Visco-3	25 mg/2.5 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use: unilaterally bilaterally.	Quantity: Refills:
Patient is interested in pati		STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided	
6	PRESCRIBER SIGN	NATURE REQUIRED (STAMP SIGNATURE NOT ALLOW	/ED)

CA, MA, NC & PR: Interchange is mandated unless Prescribe	er writes the words " No Substitution "	ATTN: New York and Iowa provide	ers, please submit electronic prescription
Prescriber's Signature:	Date:	Prescriber's Signature:	Date:
DAW / May Not Substitute		Substitution Permissible	
Dispense As written 7 Brand Medically Necessary 7 Do	NOT SUBSTITUTE / NO SUBSTITUTION /	May Substitute / Product Selection Permitted /	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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