Osteoarthritis Enrollment Form Medications A-G

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



Fax Referral To: 1-855-297-1270 Phone: 1-888-280-1190

Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927 NCPDP: 4026325

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Address:				iaci. Li maio Li romaie		
Preferred Contac Note: Carrier charge and/or text messago f unable to contact	es may apply. By providing es from CVS Specialty® abo via text or email, Specialty	primary # provided below) Text (to cell the phone number(s) and email address above out your prescription(s), account, and health contact by phone. Alternate	# provided below)	ve automated calls, emails v. Message frequency varies.		
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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)

	Pleas	e Complete Patient and I			
atient Name:		Patient DOB:			
escriber Name: _			iber Phone:		
	ON INFORMATION				
MEDICATION	STRENGTH		& DIRECTIONS	QUANTITY/REFILLS	
GenVisc 850	25 mg/3 mL prefilled syringe	week for 5 weeks. Patient to use: unilatera	syringe/vial intra-articularly once a ally bilaterally. 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	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 pat		STAMP SIGNATURE NOT A			
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / DAW / May Not Substitute Prescriber's Signature: D			May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date:	

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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