

Osteoarthritis Enrollment Form Medications A-G

(Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc 850)

Fax Referral To: 1-888-280-1191 OR 787-759-4161

Phone: 1-888-280-1190 OR 787-759-4162 Email Referral To: Customer.ServiceFax@CVSHealth.com

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

Six Simp	le Steps to	o Submittii	ng a Referra

Patient Name:       DOB:         Address:	<b>PATIENT INFO</b>	<b>DRMATION</b> (Comple	te or include demographic sheet)		
Address:				DOB:	
Sender:       Male        = female         Preferred Contract Methods:        = provided below         = provided below          Vote: Carrier charges may apply. If unable to contact via text or email, Specially Pharmacy will attempt to contact by phone.	Address:		(	City, State, ZIP Code:	
Vete: Carrier charges may spply. If unable to contact via text or email. Specially Pharmacy will attempt to contact by phone.	Gender: 🗌 Male [	Female			
Primary Phone:	Preferred Contact	Methods: 🗌 Phone (to p	primary # provided below) 🗌 Tex	t (to cell # provided below) 🗌 Email (to email p	provided below)
f Minor, Parent/Caregiver/Guardian Name (Last, First):           Petatonship to minor:           Final:         Last Four of SSN:           PRESCRIBER INFORMATION           rescriber's Name:         DEA #:           Group or Hospital:           Address:         City, State, ZIP Code:           PN #:         Group or Hospital:           Address:         Contact Person:           INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)           DIAGNOSIS AND CLINICAL INFORMATION           Needs by Date:         Ship to:           NIT 20 Bilateral primary OA, right knee           MIT 20 Bilateral primary OA right knee           MIT 20 Bilateral port-traumatic OA, of knee           MIT 30 Unilateral post-traumatic OA, of knee           MIT 30 Unilateral post-traumatic OA, of knee           MIT 40 Other bilateral secondary OA of knee           MIT 30 Unilateral post-traumatic OA, of knee           MIT 40 Other bilateral secondary OA of knee           MIT 40 Other bilateral secondary OA of knee           MIT 60 AG Knee, unspecified           PRESCRIPTION INFORMATION           Weight:         Lib/kg           Hierpield syringe           Patient to use:         unilaterally:           Bilardia	Note: Carrier charges	may apply. If unable to co			
f Minor, Parent/Caregiver/Guardian Name (Last, First):           Petatonship to minor:           Final:         Last Four of SSN:           PRESCRIBER INFORMATION           rescriber's Name:         DEA #:           Group or Hospital:           Address:         City, State, ZIP Code:           PN #:         Group or Hospital:           Address:         Contact Person:           INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)           DIAGNOSIS AND CLINICAL INFORMATION           Needs by Date:         Ship to:           NIT 20 Bilateral primary OA, right knee           MIT 20 Bilateral primary OA right knee           MIT 20 Bilateral port-traumatic OA, of knee           MIT 30 Unilateral post-traumatic OA, of knee           MIT 30 Unilateral post-traumatic OA, of knee           MIT 40 Other bilateral secondary OA of knee           MIT 30 Unilateral post-traumatic OA, of knee           MIT 40 Other bilateral secondary OA of knee           MIT 40 Other bilateral secondary OA of knee           MIT 60 AG Knee, unspecified           PRESCRIPTION INFORMATION           Weight:         Lib/kg           Hierpield syringe           Patient to use:         unilaterally:           Bilardia	Primary Phone:			Alternate Phone:	
Trail:	If Minor, Parent/Ca	aregiver/Guardian Nan	ne (Last, First):		
Trail:	<b>Relationship to min</b>	nor:			
PRESCRIBER INFORMATION         Prescriber's Name:	Email:		Last Four	of SSN: Primary Language:	
Prescriber's Name:State License #:	2 PRESCRIBER	INFORMATION			
NPI #:			State License #		
Address:		DFA # <sup>.</sup>	Group or Hospital		
INSURANCE INFORMATION       Please fax copy of prescription and insurance cards with this form, if available (front and back)         INAGNOSIS AND CLINICAL INFORMATION         Needs by Data And CLINICAL INFORMATION         Mit 7.0 Bilateral primary OA, of Knee       M17.10 Unilateral primary OA, uspecified knee         M17.13 Unilateral post-traumatic OA of Knee       M17.32 Unilateral post-traumatic OA, left knee         M17.3 O A of knee, unspecified       M17.32 Unilateral post-traumatic OA of Knee         M17.4 O there bilateral secondary OA of Knee       M17.5 Other unilateral accondary OA of Knee         M17.9 OA of knee, unspecified       Other Code:       Description         Patient Clinical Information:       Nutre Contents of prefilled syringe intra-articularly one time.       Quantity:         Inject contents of prefilled syringe intra-articularly once a week       Quantity:       Refills:         Inject contents of prefilled syringe intra-articularly once a week       Quantity:       Refills:         Gel-One       30 mg/3 mL       Inject contents of prefilled syringe intra-articularly one time.       Quantity:       Refills:       Patient to use:       Unilatera	Address:		City State ZIP Cod		
INSURANCE INFORMATION       Please fax copy of prescription and insurance cards with this form, if available (front and back)         INAGNOSIS AND CLINICAL INFORMATION         Needs by Data And CLINICAL INFORMATION         Mit 7.0 Bilateral primary OA, of Knee       M17.10 Unilateral primary OA, uspecified knee         M17.13 Unilateral post-traumatic OA of Knee       M17.32 Unilateral post-traumatic OA, left knee         M17.3 O A of knee, unspecified       M17.32 Unilateral post-traumatic OA of Knee         M17.4 O there bilateral secondary OA of Knee       M17.5 Other unilateral accondary OA of Knee         M17.9 OA of knee, unspecified       Other Code:       Description         Patient Clinical Information:       Nutre Contents of prefilled syringe intra-articularly one time.       Quantity:         Inject contents of prefilled syringe intra-articularly once a week       Quantity:       Refills:         Inject contents of prefilled syringe intra-articularly once a week       Quantity:       Refills:         Gel-One       30 mg/3 mL       Inject contents of prefilled syringe intra-articularly one time.       Quantity:       Refills:       Patient to use:       Unilatera	Phone:	Fax	Contact Person:	Contact's Phone:	
DIAGNOSIS AND CLINICAL INFORMATION         Needs by Date:       Ship to:       Patient       Office       Other:         Diagnosis (ICD-10):       M17.0 Unilateral primary OA, unspecified knee       M17.12 Unilateral primary OA, unspecified knee         M17.11 Unilateral primary OA, right knee       M17.12 Unilateral post-traumatic OA, unspecified knee         M17.2 Silateral post-traumatic OA, right knee       M17.32 Unilateral post-traumatic OA, left knee         M17.31 Unilateral post-traumatic OA, right knee       M17.32 Unilateral post-traumatic OA, left knee         M17.4 Other bilateral secondary OA of knee       M17.5 Other unilateral secondary OA of knee         M17.9 OA fikeraria       OA fikeraria         M17.9 OA fikeraria       Other Code:       Description         PRESCRIPTION INFORMATION       Weight:       Ib/kg       Height:       Meride         MEDICATION       STRENGTH       DOSE & DIRECTIONS       QUANTITY/REGIL         Durolane       60 mg/3 mL       Inject contents of prefilled syringe intra-articularly once a week       Quantity:       Refills:					
Needs by Date:       Ship to:       Patient       Office       Other:         Diagnosis (ICD-10):				nce cards with this form, if available (front and back)	
Diagnosis (ICD-10):       M17.10 Unilateral primary OA, on specified knee         M17.110 Unilateral primary OA, right knee       M17.12 Unilateral primary OA, left knee         M17.12 Bilateral post-traumatic OA of knee       M17.30 Unilateral post-traumatic OA, left knee         M17.13 Unilateral post-traumatic OA, right knee       M17.32 Unilateral post-traumatic OA, left knee         M17.40 three bilateral secondary OA of knee       M17.50 Other unilateral secondary OA of knee         M17.40 three bilateral secondary OA of knee       M17.50 Other unilateral post-traumatic OA, left knee         M17.40 three bilateral secondary OA of knee       M17.50 Other unilateral post-traumatic OA, left knee         M17.40 three bilateral secondary OA of knee       M17.50 Other unilateral post-traumatic OA, left knee         M17.40 three bilateral secondary OA of knee       M17.50 Other unilateral post-traumatic OA, left knee         M17.40 three bilateral secondary OA of knee       M17.50 Other unilateral post-traumatic OA, left knee         M17.40 three contents of prefilled syringe intra-articularly one time.       Quantity:         Patient to use:       unilaterally       Befills:         Durolane       30 mg/3 mL       Inject contents of prefilled syringe intra-articularly one time.       Quantity:         Patient to use:       unilaterally       bilaterally.       Refills:       Patient to use:       Quantity:       Refills:       Mifills:					
M17.0 Bilateral primary OA of knee       M17.10 Unilateral primary OA, left knee         M17.11 Unilateral primary OA, right knee       M17.12 Unilateral post-traumatic OA, right knee         M17.2 Bilateral post-traumatic OA, right knee       M17.30 Unilateral post-traumatic OA, unspecified knee         M17.31 Unilateral post-traumatic OA, right knee       M17.30 Unilateral post-traumatic OA, unspecified knee         M17.4 Other bilateral secondary OA of knee       M17.50 Other unilateral secondary OA of knee         M17.30 OA of knee, unspecified       Other Code:       Description         Petert Clinical Information:       Weight:       Ib/kg       Height:       in/cm         PESCRIPTION INFORMATION       STRENGTH       DOSE& DIRECTIONS       Quantity:       Refills:         Durolane       60 mg/3 mL       Inject contents of prefilled syringe intra-articularly once a week       Quantity:       Refills:         Durolane       60 mg/3 mL       Inject contents of prefilled syringe intra-articularly once a week       Quantity:       Refills:         Gel-One       30 mg/3 mL       Patient to use:       unilaterally       bilaterally.       Refills:       Patient to use:       Quantity:       Refills:       Refills:       Patient to use:       Inject contents of prefilled syringe intra-articularly once a week       Quantity:       Refills:       Supplies: Include one 20G 1.5" needle per syringe.	-		ent 🔄 Office 🔄 Other:		
M17.11 Unilateral primary OA, right knee       M17.12 Unilateral primary OA, left knee         M17.2 Bilateral post-traumatic OA of knee       M17.32 Unilateral post-traumatic OA, inght knee         M17.31 Unilateral post-traumatic OA, of knee       M17.32 Unilateral post-traumatic OA, left knee         M17.31 Unilateral secondary OA of knee       M17.32 Unilateral post-traumatic OA, inght knee         M17.30 Vnilateral post-traumatic OA, right knee       M17.32 Unilateral post-traumatic OA, left knee         M17.31 Unilateral secondary OA of knee       M17.32 Unilateral post-traumatic OA, left knee         M17.30 Vnilateral post-traumatic OA, inght knee       M17.32 Unilateral post-traumatic OA, left knee         M17.31 Unilateral post-traumatic OA, inght knee       M17.32 Unilateral post-traumatic OA, left knee         M17.31 Unilateral post-traumatic OA, inght knee       M17.32 Unilateral post-traumatic OA, left knee         M17.31 Unilateral post-traumatic OA, inght knee       M17.31 Unilateral post-traumatic OA, left knee         M17.31 Unilateral post-traumatic OA, inght knee       M17.31 Unilateral post-traumatic OA, left knee         M17.31 Unilateral post-traumatic OA, inght knee       M17.31 Unilateral post-traumatic OA, left knee         M17.31 Unilateral post-traumatic OA, inght knee       M17.31 Unilateral post-traumatic OA, left knee         M17.31 Unilateral post-traumatic OA, inght knee       M17.31 Unilateral post-traumatic OA, left knee         M17.31 Unilateral post-traumatic DA </td <td></td> <td></td> <td>_</td> <td></td> <td></td>			_		
M17.2 Bilateral post-traumatic OA, of knee       M17.30 Unilateral post-traumatic OA, unspecified knee         M17.31 Unilateral post-traumatic OA, infpt knee       M17.32 Unilateral post-traumatic OA, left knee         M17.4 Other bilateral secondary OA of knee       M17.32 Unilateral post-traumatic OA, left knee         M17.4 Other bilateral secondary OA of knee       M17.53 Unilateral post-traumatic OA, left knee         M17.4 Other bilateral secondary OA of knee       M17.53 Unilateral post-traumatic OA, left knee         M17.4 Other bilateral secondary OA of knee       M17.53 Unilateral post-traumatic OA, left knee         M17.53 Unilateral post-traumatic OA, inspecified       Description         Patient Clinical Information:       Weight:	= .				
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M17.4 Other bilateral secondary OA of Knee       M17.5 Other unilateral secondary OA of knee         M17.9 OA of knee, unspecified       Other Code:Description	🔄 M17.2 Bilateral p	post-traumatic OA of k	nee 🛛 🗌 M17.30 Unilatera	al post-traumatic OA, unspecified knee	
M17.9 OA of knee, unspecified       Other Code:	M17.31 Unilatera	al post-traumatic OA, ri	ight knee 🗌 M17.32 Unilatera	al post-traumatic OA, left knee	
Patient Clinical Information:         Allergies:	M17.4 Other bila	ateral secondary OA of	knee 🛛 🗌 M17.5 Other uni	lateral secondary OA of knee	
Allergies:	M17.9 OA of kne	e, unspecified	🗌 Other Code:	Description	
PRESCRIPTION INFORMATION       DOSE & DIRECTIONS       QUANTITY/REFIL         MEDICATION       STRENGTH       DOSE & DIRECTIONS       QUANTITY/REFILI         Durolane       60 mg/3 mL prefilled syringe       Inject contents of prefilled syringe intra-articularly one time. Patient to use:       Quantity:       Refills:         Patient for use:       unilaterally       bilaterally.       Quantity:       Refills:         Patient to use:       unilaterally       bilaterally.       Quantity:       Refills:         Patient to use:       unilaterally       bilaterally.       Quantity:       Refills:         Gel-One       30 mg/3 mL prefilled syringe       Inject contents of prefilled syringe intra-articularly one time. Patient to use:       Quantity:       Refills:       Refills:         Gel-One       30 mg/3 mL prefilled syringe       Inject contents of prefilled syringe intra-articularly one time. Patient to use:       Quantity:       Refills:       Refills:	<b>Patient Clinical Inf</b>	ormation:			
MEDICATION         STRENGTH         DOSE & DIRECTIONS         QUANTITY/REFIL           Durolane         60 mg/3 mL prefilled syringe         Inject contents of prefilled syringe intra-articularly one time. Patient to use:         Quantity:         Refills:           Purper         20 mg/2 mL prefilled syringe         Inject contents of prefilled syringe intra-articularly once a week for 3 weeks.         Quantity:         Refills:           Patient to use:         unilaterally         bilaterally.         Quantity:         Refills:           Gel-One         30 mg/3 mL prefilled syringe         Inject contents of prefilled syringe intra-articularly one time. Patient to use:         Quantity:         Quantity:           Inject contents of prefilled syringe         Inject contents of prefilled syringe intra-articularly one time. Patient to use:         Quantity:         Refills:           Inject contents of prefilled syringe intra-articularly once a week for 3 weeks.         Inject contents of prefilled syringe intra-articularly once a week for 3 weeks.         Quantity:         Refills:           Patient to use:         Unilaterally         bilaterally.         Refills:         Refills:           Inject contents of prefilled syringe         Inject contents of prefilled syringe intra-articularly once a week for 3 weeks.         Quantity:         Refills:           Patient to use:         Unilaterally         bilaterally.         Refills: <td< td=""><td>Allergies:</td><td></td><td> Weight:</td><td>lb/kg Height:in/c</td><td>m</td></td<>	Allergies:		Weight:	lb/kg Height:in/c	m
Durolane           60 mg/3 mL         prefilled syringe           Inject contents of prefilled syringe intra-articularly one time.           Quantity:	5 PRESCRIPTIC	ON INFORMATION	4		
<ul> <li>Durolane</li> <li>Durolane</li> <li>Durolane</li> <li>Durolane</li> <li>Durolane</li> <li>Defilled syringe</li> <li>Inject contents of prefilled syringe intra-articularly one time. Patient to use:</li> <li>Unject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use:</li> <li>Durolane</li> <li>Durolane</li> </ul> Quantity: Patient to use:              Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use:              Quantity:         Refills:              Refills:              Patient to use:              Patient to use:              unilaterally              bilaterally. Patient to use:              unilaterally              bilaterally. Patient to use:              Quantity:              Refills:              Patient to use:              Quantity:              Refills:              metilled syringe:              Patient to use:              Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use:             lnject contents of prefilled syringe.             lnject contents of prefilled syringe/vial intra-articularly once a week f	MEDICATION	STRENGTH	DOSE	& DIRECTIONS	QUANTITY/REFILL
Durolane       prefilled syringe       Patient to use:       unilaterally       bilaterally.       Refills:		60 mg/3 mL	Inject contents of prefilled s		
□ Euflexxa       20 mg/2 mL prefilled syringe       Inject contents of prefilled syringe intra-articularly once a week for 3 weeks.       Quantity:	Durolane	-		· <u>·</u>	
20 mg/2 mL prefilled syringe       for 3 weeks.       Patient to use:					
Luftexxa       prefilled syringe       Patient to use:unilaterallybilaterally		•	-		
Gel-One       30 mg/3 mL prefilled syringe       Inject contents of prefilled syringe intra-articularly one time. Patient to use:	🔄 Euflexxa				
Bel-One       30 mg/3 mL prefilled syringe       Inject contents of prefilled syringe intra-articularly one time.       Quantity:		promotionsjimige			
Gel-One       30 mg/3 mL prefilled syringe       Patient to use: unilaterally bilaterally. Supplies: Include one 20G 1.5" needle per syringe.       Refills:					Quantity:
prefinited syringe       Supplies: Include one 20G 1.5" needle per syringe.         Gelsyn-3       Inject contents of prefilled syringe intra-articularly once a week for 3 weeks.       Quantity:	Gel-One	-			
Gelsyn-3       16.8 mg/2 mL prefilled syringe       Inject contents of prefilled syringe intra-articularly once a week for 3 weeks.       Quantity:		prefilled syringe			
Gelsyn-3       16.8 mg/2 mL prefilled syringe       for 3 weeks. Patient to use:					Quantity:
Getsyn-3       prefilled syringe       Patient to use: unilaterally bilaterally		16.8 mg/2 ml	-	ynnige inu a-articularly Once a week	
Construction of the syname of the synam	Gelsyn-3	-			rtenus
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:		prenilieu synnige			
GenVisc 850       25 mg/3 mL prefilled syringe       for 5 weeks. Patient to use:					Quantiti
GenVISC 850     prefilled syringe     Patient to use: unilaterally bilaterally.     Supplies: Include one 23G 1.5" needle per syringe.     Supplies: Include one 23G 1.5" needle per syringe.     Ancillary supplies and kits provided as needed for administration     GPRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED     "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution /     DAW / May Not Substitute     Patient is interested in patient support programs     Stamp Signature Not Substitute / No Substitute / No Substitute / Product Selection Permitted /     Substitution Permissible		05 mag (0 mal	-	syringe/vial intra-articularly once a week	
Patient to use:	GenVisc 850	-			Refills:
Patient is interested in patient support programs  STAMP SIGNATURE NOT ALLOWED  Anciliary supplies and kits provided as needed for administration  PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)  "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute  Anciliary supplies and kits provided as needed for administration  May Substitute / Product Selection Permitted / Substitution Permissible		prefilled syringe			
© PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)         "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute       May Substitute / Product Selection Permitted / Substitution Permissible	Detiont in interested in a	tiont ourport pro success			poodod for administration
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CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" \_\_\_\_\_

ATTN: New York and Iowa providers, please submit electronic prescription

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 Speciality 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 H-Z Osteoarthritis Enrollment Form**

(Hvalgan, Hymovis, Monovisc, Orthovisc, Supartz FX, SynoJoynt, Synvisc, Synvisc-One, TriVisc, Visco-3)

	Please	e Complete Patient and Prescriber Information	
Patient Name:		Patient DOB:	
Prescriber Name:		Prescriber Phone:	
PRESCRIPTIC	<b>ON INFORMATION</b>		
MEDICATION	STRENGTH	DOSE & DIRECTIONS	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:unilaterallybilaterally.	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, Diaterally.	Quantity: Refills:

STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for administration Patient is interested in patient support programs

## **5** PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

Prescriber's Signature:	Date:	Prescriber's Signature:	Date:
DAW / May Not Substitute		Substitution Permissible	<b>-</b> .
"Dispense As Written" / Brand Medically Necessary / 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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