

Osteoarthritis Enrollment Form Medications A-G

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



Fax Referral To: 1-800-323-2445

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-800-237-2767

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____

Address: _____ City, State, ZIP Code: _____

Gender: Male Female

Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____

If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____

Relationship to minor: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: _____

Address: _____ City, State, ZIP Code: _____

Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: Patient Office Other: _____

Diagnosis (ICD-10):

- | | |
|--|--|
| <input type="checkbox"/> M17.0 Bilateral primary OA of knee | <input type="checkbox"/> M17.10 Unilateral primary OA, unspecified knee |
| <input type="checkbox"/> M17.11 Unilateral primary OA, right knee | <input type="checkbox"/> M17.12 Unilateral primary OA, left knee |
| <input type="checkbox"/> M17.2 Bilateral post-traumatic OA of knee | <input type="checkbox"/> M17.30 Unilateral post-traumatic OA, unspecified knee |
| <input type="checkbox"/> M17.31 Unilateral post-traumatic OA, right knee | <input type="checkbox"/> M17.32 Unilateral post-traumatic OA, left knee |
| <input type="checkbox"/> M17.4 Other bilateral secondary OA of knee | <input type="checkbox"/> M17.5 Other unilateral secondary OA of knee |
| <input type="checkbox"/> M17.9 OA of knee, unspecified | <input type="checkbox"/> Other Code: _____ Description: _____ |

Patient Clinical Information:

Allergies: _____

Weight: _____ lb/kg

Height: _____ in/cm

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Durolane	60 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally.	Quantity: _____ Refills: _____
<input type="checkbox"/> Euflexxa	20 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe.	Quantity: _____ Refills: _____
<input type="checkbox"/> Gel-One	30 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe.	Quantity: _____ Refills: _____
<input type="checkbox"/> Gelsyn-3	16.8 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 21G 1.5" needle per syringe.	Quantity: _____ Refills: _____
<input type="checkbox"/> 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: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 23G 1.5" needle per syringe.	Quantity: _____ Refills: _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Prescriber's Signature: _____ Date: _____	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: _____ Date: _____
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 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 H-Z

Osteoarthritis Enrollment Form

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

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Hyalgan	<input type="checkbox"/> 20 mg/2 mL prefilled syringe <input type="checkbox"/> 20 mg/2 mL vial	Inject contents of prefilled syringe/vial intra-articularly once a week for 5 weeks. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe.	Quantity: _____ Refills: _____
<input type="checkbox"/> Hymovis	24 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 2 weeks. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe.	Quantity: _____ Refills: _____
<input type="checkbox"/> Monovisc	88 mg/4 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally.	Quantity: _____ Refills: _____
<input type="checkbox"/> Orthovisc	30 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for ___ weeks. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe.	Quantity: _____ Refills: _____
<input type="checkbox"/> 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: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 23G 1.5" needle per syringe.	Quantity: _____ Refills: _____
<input type="checkbox"/> SynoJoynt	20 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally	Quantity: _____ Refills: _____
<input type="checkbox"/> Synvisc	16 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe	Quantity: _____ Refills: _____
<input type="checkbox"/> Synvisc-One	48 mg/6 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe	Quantity: _____ Refills: _____
<input type="checkbox"/> TriVisc	25mg/3mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally.	Quantity: _____ Refills: _____
<input type="checkbox"/> 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: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally.	Quantity: _____ Refills: _____

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