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 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):

☐ M17.0 Bilateral primary OA of knee
☐ M17.11 Unilateral primary OA, right knee
☐ M17.2 Bilateral post-traumatic OA of knee
☐ M17.31 Unilateral post-traumatic OA, right knee
☐ M17.4 Other bilateral secondary OA of knee
☐ M17.9 OA of knee, unspecified
☐ M17.10 Unilateral primary OA, unspecified knee
☐ M17.12 Unilateral primary OA, left knee
☐ M17.30 Unilateral post-traumatic OA, unspecified knee
☐ M17.32 Unilateral post-traumatic OA, left knee
☐ M17.5 Other unilateral secondary OA of knee
☐ Other Code: ______ Description ______________

Patient Clinical Information:

Allergies: ____________________ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Durolane	60 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: ☐ unilaterally ☐ bilaterally.	Quantity: ______ Refills: ______
☐ Euflexxa	20 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: ______
☐ Gel-One	30 mg/3 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: ______
☐ 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: ☐ unilaterally ☐ bilaterally. ☐ Supplies: Include one 21G 1.5" needle per syringe.	Quantity: ______ Refills: ______
☐ 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: ______

☐ 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.

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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
☐ 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: ________

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