Please fax both pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.516.3319.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Osteoarthritis

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

☐ Male ☐ Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion clinic contact name _____ Phone _____ E-mail _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Current weight _____ kg/lbs Date recorded _____

EXPECTED DATE OF FIRST/NEXT INJECTION _____ DATE OF LAST INJECTION (if applicable) _____

Agency nurse to visit home for injection: ☐ Yes ☐ No

Agency name & phone _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Dose	Directions	Quantity/Refills
☐ Durolane® (hyaluronic acid)	60mg/3mL prefilled syringe	Inject contents of syringe intra-articularly once. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) Refills _____
☐ Euflexxa® (sodium hyaluronate)	20mg/2mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) Refills _____
☐ Gel-One® (hyaluronate sodium)	30mg/3mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) Refills _____
☐ Gelsyn-3™ (sodium hyaluronate)	16.8mg/2mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) Refills _____
☐ Hyalgan® (sodium hyaluronate)	☐ 20mg/2mL prefilled syringe ☐ 20mg/2mL vial	Inject contents of prefilled syringe/vial intra-articularly once a week for _____ weeks. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) or vial(s) Refills _____
☐ Hymovis® (hyaluronan)	24mg/3mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 2 weeks. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) Refills _____
☐ Monovisc® (hyaluronan)	88mg/4mL prefilled syringe	Inject contents of syringe intra-articularly once. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) Refills _____
☐ Orthovisc® (hyaluronan)	30mg/2mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for _____ weeks. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) Refills _____
☐ Supartz FX™ (sodium hyaluronate)	25mg/2.5mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 5 weeks. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) Refills _____
☐ Synvisc One™ (hylan G-F 20)	48mg/6mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) Refills _____
☐ Synvisc® (hyaluronate)	16mg/2mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) Refills _____
☐ Triluron™ (sodium hyaluronate) 1 Syringe/Pack	20mg/2mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) Refills _____
☐ Visco-3™ (sodium hyaluronate)	25mg/2.5mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Please check one: ☐ Right knee ☐ Left knee ☐ Both knees	Quantity _____ Syringe(s) Refills _____
☐ Other			Quantity _____ Syringe(s) Refills _____
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			Send quantity sufficient for medication days supply

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

If NP or PA, under direction of Dr. _____ State License No: _____

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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