Prescription & Enrollment Form

Osteoarthritis

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's name _____

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

Street address _____ Apt # _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____

Home phone _____ Work phone _____ Cell phone _____

Evening phone _____ E-mail address _____

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

Please attach front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____

Insured's name _____

Insured's employer _____ Relationship to patient _____

Identification # _____ Policy/group # _____

Prescription card: ❑ Yes ❑ No If yes, carrier _____

Policy # _____ Group # _____ Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's name and title _____

If NP or PA, under direction of Dr. _____

Office contact and title _____

Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____

Deliver product to: ❑ Office ❑ Clinic (To be administered in MD office)

Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____

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 _____

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
❑ Durolane® (hyaluronic acid)	60 mg/3 mL prefilled syringe	Inject contents of syringe intra-articularly once. Please check one: ❑ Right knee ❑ Left knee ❑ Both knees	Quantity _____ Refills _____
❑ Euflexxa® (sodium hyaluronate)	20 mg/2 mL 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 _____ Refills _____
❑ Gel-One® (hyaluronate sodium)	30 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly. Please check one: ❑ Right knee ❑ Left knee ❑ Both knees	Quantity one Refills zero
❑ Gelsyn-3™ (sodium hyaluronate)	16.8 mg/2 mL 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 _____ Refills _____
❑ Hyalgan® (sodium hyaluronate)	❑ 20 mg/2 mL prefilled syringe ❑ 20 mg/2 mL vial	Inject contents of prefilled syringe/vial intra-articularly once a week for _____ weeks. Please check one: ❑ Right knee ❑ Left knee ❑ Both knees	Quantity _____ Refills _____
❑ Hymovis® (hyaluronan)	24 mg/3 mL prefilled syringe (2 pack)	Inject contents of prefilled syringe intra-articularly once a week for 2 weeks (7 days apart). Please check one: ❑ Right knee ❑ Left knee ❑ Both knees	Quantity _____ Refills _____
❑ Monovisc® (hyaluronan)	88 mg/4 mL prefilled syringe	Inject contents of syringe intra-articularly once. Please check one: ❑ Right knee ❑ Left knee ❑ Both knees	Quantity _____ Refills _____
❑ Orthovisc® (hyaluronan)	30 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for _____ weeks. Please check one: ❑ Right knee ❑ Left knee ❑ Both knees	Quantity _____ Refills _____
❑ Supartz FX™ (sodium hyaluronate)	25 mg/2.5 mL 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 _____ Refills _____
❑ Synvisc One™ (hylan G-F 20)	48 mg/6 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly. Please check one: ❑ Right knee ❑ Left knee ❑ Both knees	Quantity one Refills zero
❑ Synvisc® (hyaluronate)	16 mg/2 mL 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 _____ Refills _____
❑ Visco-3™ (sodium hyaluronate)	25 mg/2.5 mL 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 _____ Refills _____
❑ Other			Quantity _____ Refills _____
❑ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy		As needed for administration	Send quantity sufficient for medication days supply

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

By signing below, I certify that the above therapy is medically necessary.

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

PHYSICIAN SIGNATURE REQUIRED

_____ _____ _____ _____

Date Substitution allowed Date Dispense as written

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.

Please fax completed form to the Osteoarthritis team at 888.302.1028. To reach your team, call toll-free 888.608.9010.

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