

Osteoarthritis



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 _____

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

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
<input type="checkbox"/> Durolane® (hyaluronic acid)	60 mg/3 mL prefilled syringe	Inject contents of syringe intra-articularly once. Please check one: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees	Quantity _____ Refills _____
<input type="checkbox"/> 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: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees	Quantity _____ Refills _____
<input type="checkbox"/> Gel-One® (hyaluronate sodium)	30 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly. Please check one: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees	Quantity one Refills zero
<input type="checkbox"/> 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: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees	Quantity _____ Refills _____
<input type="checkbox"/> Hyalgan® (sodium hyaluronate)	<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 _____ weeks. Please check one: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees	Quantity _____ Refills _____
<input type="checkbox"/> 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: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees	Quantity _____ Refills _____
<input type="checkbox"/> Monovisc® (hyaluronan)	88 mg/4 mL prefilled syringe	Inject contents of syringe intra-articularly once. Please check one: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees	Quantity _____ Refills _____
<input type="checkbox"/> Orthovisc® (hyaluronan)	30 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for _____ weeks. Please check one: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees	Quantity _____ Refills _____
<input type="checkbox"/> 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: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees	Quantity _____ Refills _____
<input type="checkbox"/> Synvisc One™ (hylan G-F 20)	48 mg/6 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly. Please check one: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees	Quantity one Refills zero
<input type="checkbox"/> Synvisc® (hyaluronate)	16 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Please check one: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees	Quantity _____ Refills _____
<input type="checkbox"/> 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: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> Both knees	Quantity _____ Refills _____
<input type="checkbox"/> Other			Quantity _____ Refills _____
<input type="checkbox"/> 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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