Osteoarthritis (OA) Enrollment Form

CVS specialty™

Fax Referral To: 1-800-323-2445 **Phone: 1-800-237-2767**
Email Referral To: customerservicefax@caremark.com

Six Simple Steps to Submitting a Referral

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

Patient Name: _____
Address: _____
City, State, ZIP: _____
Preferred Contact Method: ☐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: _____ ☐Home ☐Cell ☐Work
Alternate Phone: _____ ☐Home ☐Cell ☐Work
DOB: _____ Gender: ☐Male ☐Female
Email: _____
Last Four of SSN: _____ Primary Language: _____

❷ PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Fax: _____
Contact Person: _____
Contact's Phone: _____

❸ INSURANCE INFORMATION

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

❹ DIAGNOSIS AND CLINICAL INFORMATION

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

Diagnosis (ICD-10):

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

For additional ICD-10 information, please visit www.CVSspecialty.com/ICD10

Patient Clinical Information: Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm

❺ PRESCRIPTION INFORMATION

MEDICATION	DOSE/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.		
☐ 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.		
☐ 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.		
☐ 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.		
☐ 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.		
☐ 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.		
☐ 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.		
☐ Monovisc®	88 mg/4 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use ☐ unilaterally ☐bilaterally.		
☐ 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.		
☐ 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.		
☐ 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		
☐ 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		
☐ 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.		

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

❻

X _____ PHYSICIAN SIGNATURE REQUIRED X _____

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN

75-38667A 030918