

Osteoarthritis (OA) Enrollment Form



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

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____
 Address: _____
 City, State, ZIP: _____

Preferred Contact Method: Phone Text Email
(to primary # provided below) (to cell # provided below) (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: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
 State License #: _____ NPI #: _____
 DEA #: _____

Group or Hospital: _____
 Address: _____
 City, State, ZIP: _____
 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 M17.10 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

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> DUROLANE®	60 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally.		
<input type="checkbox"/> Euflexxa®	20 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe.		
<input type="checkbox"/> Gel-One®	30 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe.		
<input type="checkbox"/> 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 <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 21G 1.5" needle per syringe.		
<input type="checkbox"/> 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 <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 23G 1.5" needle per syringe.		
<input type="checkbox"/> Hyalgan®	<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 5 weeks. Patient to use <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe.		
<input type="checkbox"/> Hymovis®	24 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 2 weeks. Patient to use <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe.		
<input type="checkbox"/> Monovisc®	88 mg/4 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally.		
<input type="checkbox"/> Orthovisc®	30 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for _____ weeks. Patient to use <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe.		
<input type="checkbox"/> 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 <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 23G 1.5" needle per syringe.		
<input type="checkbox"/> Synvisc®	16 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Patient to use <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe.		
<input type="checkbox"/> Synvisc-One®	48 mg/6 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally. <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe.		
<input type="checkbox"/> 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 <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally.		

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED

6 X _____ X _____
 PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN

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