Fax: 1-877-405-7940
Phone: 1-800-486-2668

Humana Specialty Pharmacy®

Monday - Friday: 8 a.m. - 11 p.m. ET
Saturday: 8 a.m. - 6:30 p.m. ET

Viscosupplement Prescription Form

Patient Information

Patient:_____ ☐ Female ☐ Male Humana ID:_____ DOB:_____
Address_____ City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Other Medical Conditions:_____
Caregiver:_____ Allergies:_____ ☐ NKDA

Clinical Information

Height:_____ Weight:_____ ☐ lb ☐ kg Date:_____
ICD-10 Code(s):_____ Diagnosis:_____ Diagnosis Date:_____
Concurrent Medications:_____
Expected Date of First or Next Injection:_____

If applicable, please provide each previous therapy and its dates:

Therapy:	Discontinuation Reason:	Dates:
☐ _____	_____	_____
☐ _____	_____	_____
☐ _____	_____	_____

Prescription Information

Medication	Knee	Directions	Quantity	Refills
☐ Durolane 20mg/ml 3ml PFS	☐ Left ☐ Right ☐ Bilateral	_____ _____	_____ Syringes	_____
☐ Euflexxa 10mg/ml 2ml PFS	☐ Left ☐ Right ☐ Bilateral	_____ _____	_____ Syringes	_____
☐ Gel-one 10mg/ml 3ml PFS	☐ Left ☐ Right ☐ Bilateral	_____ _____	_____ Syringes	_____
☐ Gelsyn-3 8.4mg/ml 2ml PFS	☐ Left ☐ Right ☐ Bilateral	_____ _____	_____ Syringes	_____
☐ Genvisc 850 10mg/ml 2.5ml PFS	☐ Left ☐ Right ☐ Bilateral	_____ _____	_____ Syringes	_____
☐ Hyalgan 10mg/ml 2ml PFS ☐ Hyalgan 10mg/ml 2ml Vial	☐ Left ☐ Right ☐ Bilateral	_____ _____	☐ _____ Syringes ☐ _____ Vials	_____
☐ Hymovis 8mg/ml 3ml PFS	☐ Left ☐ Right ☐ Bilateral	_____ _____	_____ Syringes	_____
☐ Monovisc 22mg/ml 4ml PFS	☐ Left ☐ Right ☐ Bilateral	_____ _____	_____ Syringes	_____
☐ Orthovisc 15mg/ml 2ml PFS	☐ Left ☐ Right ☐ Bilateral	_____ _____	_____ Syringes	_____
☐ Supartz FX 10mg/ml 2.5ml PFS	☐ Left ☐ Right ☐ Bilateral	_____ _____	_____ Syringes	_____
☐ Synvisc 8mg/ml 2ml PFS ☐ Synvisc One 8mg/ml 6ml PFS	☐ Left ☐ Right ☐ Bilateral	_____ _____	_____ Syringes	_____
☐ Visco-3 10mg/ml 2.5ml PFS	☐ Left ☐ Right ☐ Bilateral	_____ _____	_____ Syringes	_____

Prescriber and Shipping Information (Please print.)

Prescriber:_____ NPI:_____ Contact:_____

Ship to: ☐ Patient ☐ Office ☐ Alternate:_____
Office Address:_____ City:_____ State:_____ Zip Code:_____
Office Phone Number:_____ Office Fax Number:_____
Signature:_____ Date:_____
We will dispense this prescription as generic, unless the prescriber indicates “Dispense as Written”._____