Osteoarthritis Enrollment Form
Medications A-G

CVS specialty™

Fax Referral To: 1-800-323-2445
Email Referral To: customerservicefax@caremark.com

Phone: 1-800-237-2767

Six Simple Steps to Submitting a Referral

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

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

Preferred Contact Methods: ☐ 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: _____ Alternate Phone: _____ 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 CVS Specialty Healthcare Professionals Website
https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

MEDICATION	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.	Quantity:_____ Refills:_____
☐ 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.	Quantity:_____ Refills:_____
☐ 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.	Quantity:_____ Refills:_____
☐ 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.	Quantity:_____ Refills:_____

☐ 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 (Date)

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Medications G-Z
Osteoarthritis Enrollment Form

(GenVisc® 850, Hyalgan®, Hymovis®, Monovisc®, Orthovisc®, Supartz FX™, Synvisc®, Synvisc-One®, TriVisc™, Visco-3™)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ 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.	Quantity:_____ Refills:_____
☐ 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.	Quantity:_____ Refills:_____
☐ 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.	Quantity:_____ Refills:_____
☐ Monovisc	88 mg/4 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: ☐ unilaterally ☐ bilaterally.	Quantity:_____ Refills:_____
☐ 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.	Quantity:_____ Refills:_____
☐ 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.	Quantity:_____ Refills:_____
☐ 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	Quantity:_____ Refills:_____
☐ 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	Quantity:_____ Refills:_____
☐ TriVisc	25mg/3mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: ☐ unilaterally ☐ bilaterally.	Quantity:_____ Refills:_____
☐ 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.	Quantity:_____ Refills:_____

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

❻ X_____ X_____

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