



Viscosupplementation Medication Request

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809
www.AetnaSpecialtyPharmacy.com

Customer Service: 1-866-782-ASRX (1-866-782-2779)

Fax Order Submission: 1-866-FAX-ASRX (1-866-329-2779)

For your convenience, this medication request may be submitted via E-PRESCRIBE to Aetna Specialty Pharmacy

Aetna Specialty Pharmacy will verify benefits and contact members to confirm delivery before medication is shipped.

Today's Date:	Date Needed:
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A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:		City:		State:	ZIP:
Home Phone:		Work Phone:		Cell Phone:	
Weight:	Height:	Allergies:			

B. INSURANCE INFORMATION

Carrier Name: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Member ID #: _____	If yes Carrier Name: _____
Group #: _____	Member ID#: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, ID #: _____

C. PHYSICIAN INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA	
Address:		City:		State:	ZIP:
Phone:	Fax:	DEA #:	NPI #:	Office Contact:	

D. DIAGNOSIS

Primary ICD Code: _____	Other ICD Code: _____
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E. PRESCRIPTION

Please refer to the insurance carrier's provider precertification list to verify precertification requirements.

Medication	Directions	Quantity
<input type="checkbox"/> DUROLANE	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> One time injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 dose <input type="checkbox"/> 2 doses <input type="checkbox"/> Other: _____
<input type="checkbox"/> EUFLEXXA	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> Inject once weekly for 3 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 box (3 doses) <input type="checkbox"/> 2 boxes (6 doses) <input type="checkbox"/> Other: _____
<input type="checkbox"/> GEL-ONE	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> One time injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 dose <input type="checkbox"/> 2 doses <input type="checkbox"/> Other: _____
<input type="checkbox"/> GELSYN-3	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> Inject once weekly for 3 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 3 doses <input type="checkbox"/> 6 doses <input type="checkbox"/> Other: _____
<input type="checkbox"/> GENVISC 850	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> Inject once weekly for 3 weeks <input type="checkbox"/> Inject once weekly for 4 weeks <input type="checkbox"/> Inject once weekly for 5 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 3 doses <input type="checkbox"/> 6 doses <input type="checkbox"/> 4 doses <input type="checkbox"/> 8 doses <input type="checkbox"/> 5 doses <input type="checkbox"/> 10 doses <input type="checkbox"/> Other: _____
<input type="checkbox"/> HYALGAN	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> Inject once weekly for 3 weeks <input type="checkbox"/> Inject once weekly for 4 weeks <input type="checkbox"/> Inject once weekly for 5 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 3 doses <input type="checkbox"/> 6 doses <input type="checkbox"/> 4 doses <input type="checkbox"/> 8 doses <input type="checkbox"/> 5 doses <input type="checkbox"/> 10 doses <input type="checkbox"/> Other: _____
<input type="checkbox"/> HYMOVIS	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> Inject once weekly for 2 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 box (2 doses) <input type="checkbox"/> 2 boxes (4 doses) <input type="checkbox"/> Other: _____

Ship to: Physician's Office Patient Other address:

Interchange is mandated unless practitioner handwrites the words "MEDICALLY NECESSARY" for each medication.

Prescriber's Signature (Required by Law):

Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. This pharmacy is a for-profit entity.



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Group #: _____	Member ID#: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, ID #: _____

C. PHYSICIAN INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA	
Address:		City:		State:	ZIP:
Phone:	Fax:	DEA #:	NPI #:	Office Contact:	

D. DIAGNOSIS

Primary ICD Code: _____	Other ICD Code: _____
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E. PRESCRIPTION

Please refer to the insurance carrier's provider precertification list to verify precertification requirements.

Medication	Directions	Quantity
<input type="checkbox"/> MONOVISC	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> One time injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 dose <input type="checkbox"/> 2 doses <input type="checkbox"/> Other: _____
<input type="checkbox"/> ORTHOVISC	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> Inject once weekly for 3 weeks <input type="checkbox"/> Inject once weekly for 4 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 3 doses <input type="checkbox"/> 6 doses <input type="checkbox"/> 4 doses <input type="checkbox"/> 8 doses <input type="checkbox"/> Other: _____
<input type="checkbox"/> SUPARTZ FX	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> Inject once weekly for 3 weeks <input type="checkbox"/> Inject once weekly for 4 weeks <input type="checkbox"/> Inject once weekly for 5 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 3 doses <input type="checkbox"/> 6 doses <input type="checkbox"/> 4 doses <input type="checkbox"/> 8 doses <input type="checkbox"/> 5 doses <input type="checkbox"/> 10 doses <input type="checkbox"/> Other: _____
<input type="checkbox"/> SYNVISIC	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> Inject once weekly for 3 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 box (3 doses) <input type="checkbox"/> 2 boxes (6 doses) <input type="checkbox"/> Other: _____
<input type="checkbox"/> SYNVISIC-ONE	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> One time injection <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 dose <input type="checkbox"/> 2 doses <input type="checkbox"/> Other: _____
<input type="checkbox"/> TRIVISC	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> Inject once weekly for 3 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 box (3 doses) <input type="checkbox"/> 2 boxes (6 doses) <input type="checkbox"/> Other: _____
<input type="checkbox"/> VISCO-3	<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees <input type="checkbox"/> Other joint: _____ <input type="checkbox"/> Inject once weekly for 3 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 box (3 doses) <input type="checkbox"/> 2 boxes (6 doses) <input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____	_____	_____

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