

# Osteoarthritis Enrollment Form Medications A-G



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):

- |  |  |
|--|--|
| <input type="checkbox"/> M17.0 Bilateral primary OA of knee              | <input type="checkbox"/> M17.10 Unilateral primary OA, unspecified knee        |
| <input type="checkbox"/> M17.11 Unilateral primary OA, right knee        | <input type="checkbox"/> M17.12 Unilateral primary OA, left knee               |
| <input type="checkbox"/> M17.2 Bilateral post-traumatic OA of knee       | <input type="checkbox"/> M17.30 Unilateral post-traumatic OA, unspecified knee |
| <input type="checkbox"/> M17.31 Unilateral post-traumatic OA, right knee | <input type="checkbox"/> M17.32 Unilateral post-traumatic OA, left knee        |
| <input type="checkbox"/> M17.4 Other bilateral secondary OA of knee      | <input type="checkbox"/> M17.5 Other unilateral secondary OA of knee           |
| <input type="checkbox"/> M17.9 OA of knee, unspecified                   | <input type="checkbox"/> 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)

<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
<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.	Quantity: _____ Refills: _____
<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.	Quantity: _____ Refills: _____
<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.	Quantity: _____ Refills: _____
<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.	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

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.

**CONFIDENTIALITY NOTICE:** This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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# 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
<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.	Quantity: _____ Refills: _____
<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.	Quantity: _____ Refills: _____
<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.	Quantity: _____ Refills: _____
<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.	Quantity: _____ Refills: _____
<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.	Quantity: _____ Refills: _____
<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.	Quantity: _____ Refills: _____
<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	Quantity: _____ Refills: _____
<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	Quantity: _____ Refills: _____
<input type="checkbox"/> TriVisc	25mg/3mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time. Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally.	Quantity: _____ Refills: _____
<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.	Quantity: _____ Refills: _____

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

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  DISPENSE AS WRITTEN \_\_\_\_\_ (Date)

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