



# Hyaluronan Injection Enrollment Form

1. DOCTOR/PRESCRIBER FILL OUT AND  
FAX TO: 1-888-773-7386 or Call: 1-888-773-7376

- Faxes will only be accepted from a doctor's office.
- Class II medications cannot be faxed.

## Patient Information New Rx Refill

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone #1: \_\_\_\_\_ Phone #2: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  No Known Allergies  
 Health Conditions: \_\_\_\_\_  
 Expected Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Statement of Medical Necessity

Patient Weight: \_\_\_\_\_  lbs  kg Primary Diagnosis: \_\_\_\_\_ ICD9 Code: \_\_\_\_\_  
 CLINICAL INFORMATION  Left Knee  Right Knee  Both Knees  Not Applicable

### Temporomandibular Joint (TMJ) Disorders Only:

- Treatment is for pain due to reducing and non-reducing disc displacement disease of temporomandibular joint (TMJ) disorders
- Treatment is a single course of intra-articular injections [A single course is weekly injections (7 days apart) for 3 to 5 consecutive weeks]

## Drug Delivery Information If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

In Office Delivery  Home Delivery for Self Injection/Administration  Home Delivery for Home Health Administration  
 Other: \_\_\_\_\_ Contact: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_

## Insurance Information Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_  
 Insured: \_\_\_\_\_ Insured: \_\_\_\_\_  
 ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Rx Drug Card #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Rx Drug Card #: \_\_\_\_\_  
 Rx Bin #: \_\_\_\_\_ Rx PCN #: \_\_\_\_\_ Rx Grp #: \_\_\_\_\_ Rx Bin #: \_\_\_\_\_ Rx PCN #: \_\_\_\_\_ Rx Grp #: \_\_\_\_\_

## Doctor/Prescriber Information NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_  
 City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

## 2. COMPLETE THE FOLLOWING RX FORM -OR- TAPE RX HERE

Rx		Date: ____/____/____
Drug Name/Form/Strength	Directions for Use	
<input type="checkbox"/> Euflexxa® 10mg/mL 2mL syringe		
<input type="checkbox"/> Hyalgan 10mg/mL 2mL syringe		
<input type="checkbox"/> Orthovisc 15mg/mL 2mL syringe		
<input type="checkbox"/> Supartz 10mg/mL 2.5mL syringe		
<input type="checkbox"/> Synvisc® 8mg/mL 2mL syringe <input type="checkbox"/> Synvisc One™ 8mg/mL 6mL syringe		
Other:		
		Quantity: _____ Refills: _____
X _____	X _____	
Doctor/Prescriber Signature – Dispense as Written Stamped signatures cannot be accepted		Doctor/Prescriber Signature – Substitution Permissible Stamped signatures cannot be accepted

Federally approved, generic-equivalent medications will be dispensed for brand-name medications unless otherwise directed by the patient, physician, or health plan.  
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