CuraScript

Reset Form

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: _____ Phone #1: _____ Phone #2: _____

Address: _____ Allergies: _____ ☐ No Known Allergies

City: _____ ST: _____ Zip: _____ Health Conditions: _____

Date of Birth (mm/dd/yyyy): __ __ / __ __ / __ __ __ __ 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
☐ Euflexxa® 10mg/mL 2mL syringe	
☐ Hyalgan 10mg/mL 2mL syringe	
☐ Orthovisc 15mg/mL 2mL syringe	
☐ Supartz 10mg/mL 2.5mL syringe	
☐ Synvisc® 8mg/mL 2mL syringe ☐ Synvisc One™ 8mg/mL 6mL syringe	
Other:	Quantity: _____ Refills: _____

X _____

Doctor/Prescriber Signature – Dispense as Written
Stamped signatures cannot be accepted

X _____

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.