OPTUMRx®

Sodium Hyaluronate Enrollment Form

Fax To: (800) 853-3844 Phone: (866) 815-5338

UnitedHealthcare®

Must be obtained through OptumRx

☐ Gel-One® ☐ Hyalgan® ☐ Orthovisc® ☐ Supartz®

May be obtained through OptumRx or through buy and bill

☐ Euflexxa® ☐ Synvisc® ☐ Synvisc-One®

Patient Information

Patient Name: M ☐ F ☐			
Insurance ID #:	Date of Birth:	Height:	Wt:
Street Address:		Apt/Suite:	
City, St., Zip:			
Phone:	Alt. Phone:		

Prescriber Information

Prescriber's Name:		DEA/NPI No:
Street Address:		Suite:
City, St., Zip:		
Phone:	Ext.	Fax:
Contact at MD Office:		

Diagnosis Information

NOTICE: Attach pertinent clinical info supporting each stated diagnosis

- ☐ 524.62 Arthralgia of temporomandibular joint
- ☐ 524.63 Articular disc disorder (reducing or non-reducing) of temporomandibular joint
- ☐ 524.69 Other specified temporomandibular joint disorders
- ☐ 715.16 Primary localized osteoarthrosis, lower leg
- ☐ 715.26 Secondary localized osteoarthrosis, lower leg
- ☐ 715.36 Localized osteoarthrosis not specified whether primary or secondary, lower leg
- ☐ 715.96 Osteoarthrosis, unspecified whether generalized or localized, lower leg
- ☐ 716.56 Unspecified polyarthropathy or polyarthritis, lower leg
- ☐ 716.86 Other specified arthropathy, lower leg
- ☐ 716.96 Unspecified arthropathy, lower leg
- ☐ 719.46 Pain in joint, lower leg
- ☐ Other: ____________________

Insurance Information – PRIMARY/SECONDARY

Primary Insurance	Subscriber:	ID#
	Name of Insurer:	Phone:
Secondary Insurance	Subscriber:	ID#
	Name of Insurer:	Phone:

Attach copy of the Front and Back of Insurance Card(s)

Prescription Information

1. Has the member had any sodium hyaluronate (drugs at the top of the form) in the past? ☐Yes ☐No
2. If yes, has it been **LESS THAN** 6 months since the last sodium hyaluronate injection for the SAME knee or TMJ? ☐Yes ☐No Date of Last Injection____________________
3. If **yes**, what was the site of injection? ☐Right Knee ☐Left Knee ☐Bilateral Knees ☐TMJ

Delivery Instructions:

- Date medication needed: _____ /_____ /_____
- Additional shipping instructions? ☐Yes ☐No

If **yes**, please specify: ____________________

℞

Drug:

Sig:

Date: ____ /_____ /_____

# of injections:____________________ **Refill:**________________

_____**Right Knee** _____**Left Knee** _____**Bilateral Knees** _____**TMJ**

Physician's Signature:____________________

DAW________________(Initial here)

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