



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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