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Prescription & Enrollment Form
Osteoarthritis

accredo[®]
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information



Please provide copies of front and back of all medical and prescription insurance cards.

New patient Current patient

Patient's first name _____ Last name _____ Middle initial _____

Male Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

OK to leave message with alternate caregiver/contact

Patient's primary language: English Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: Patient's home Prescriber's office Inflation site If inflation site, complete information below:

Infusion info: Inflation site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Inflation clinic contact name _____ Phone _____ E-mail _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Current weight _____ kg/lbs Date recorded _____

EXPECTED DATE OF FIRST/NEXT INJECTION _____ DATE OF LAST INJECTION (if applicable) _____

Agency nurse to visit home for injection: Yes No

Agency name & phone _____

NKDA Known drug allergies _____

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Dose	Directions	Quantity/Refills
Durolane® (hyaluronic acid)	60mg/3mL prefilled syringe	Inject contents of syringe intra-articularly once. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) Refills _____
Euflexxa® (sodium hyaluronate)	20mg/2mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) Refills _____
Gel-One® (hyaluronate sodium)	30mg/3mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) Refills _____
Gelsyn-3™ (sodium hyaluronate)	16.8mg/2mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) Refills _____
Hyalgan® (sodium hyaluronate)	20mg/2mL prefilled syringe 20mg/2mL vial	Inject contents of prefilled syringe/vial intra-articularly once a week for _____ weeks. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) or vial(s) Refills _____
Hymovis® (hyaluronan)	24mg/3mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 2 weeks. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) Refills _____
Monovisc® (hyaluronan)	88mg/4mL prefilled syringe	Inject contents of syringe intra-articularly once. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) Refills _____
Orthovisc® (hyaluronan)	30mg/2mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for _____ weeks. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) Refills _____
Supartz FX™ (sodium hyaluronate)	25mg/2.5mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 5 weeks. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) Refills _____
Synvisc One™ (hylan G-F 20)	48mg/6mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) Refills _____
Synvisc® (hyaluronate)	16mg/2mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) Refills _____
Triluron™ (sodium hyaluronate) 1 Syringe/Pack	20mg/2mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) Refills _____
Visco-3™ (sodium hyaluronate)	25mg/2.5mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks. Please check one: Right knee Left knee Both knees	Quantity _____ Syringe(s) Refills _____
Other			Quantity _____ Syringe(s) Refills _____
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			Send quantity sufficient for medication days supply

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

**SIGN
HERE**

Date _____ Dispense as written _____ Date _____ Substitution allowed _____

If NP or PA, under direction of Dr. _____ State License No: _____

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.



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