**Please fax both pages of completed form to your team at 808.650.6487.**

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

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 ☐ Influsion site If infusion site, complete information below:

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

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion 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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