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Prescription & Enrollment Form  
**Osteoarthritis**



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    Infusion 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 _____
<b>Ancillary Supplies: (Prescriber to strike through if not required)</b> 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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