Osteoarthritis Enrollment Form

CVS specialty®

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
NCPDP: 1203417

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____ City, State, ZIP Code: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____ Fax _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)
Is the Patient Insured? Yes ☐ No ☐ Is the Patient enrolled or eligible for Medicare/Medicaid? Yes ☐ No ☐
Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____
Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ M17.0 Bilateral primary OA of knee
☐ M17.10 Unilateral primary OA, unspecified knee
☐ M17.11 Unilateral primary OA, right knee
☐ M17.12 Unilateral primary OA, left knee
☐ M17.2 Bilateral post-traumatic OA of knee
☐ M17.30 Unilateral post-traumatic OA, unspecified knee
☐ M17.31 Unilateral post-traumatic OA, right knee
☐ M17.32 Unilateral post-traumatic OA, left knee
☐ M17.4 Other bilateral secondary OA of knee
☐ M17.5 Other unilateral secondary OA of knee
☐ M17.9 OA of knee, unspecified
☐ Other Code: _____ Description _____

Patient Clinical Information:

Allergies: _____ Has patient previously been treated for Osteoarthritis? ☐ Yes ☐ No
If YES, list all previous medications: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Gel-One	30 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time Patient to use: ☐ unilaterally ☐ bilaterally ☐ Supplies: Include one 20G 1.5" needle per syringe	Quantity: _____
☐ Synvisc	16 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks Patient to use: ☐ unilaterally ☐ bilaterally ☐ Supplies: Include one 20G 1.5" needle per syringe	Quantity: _____
☐ Synvisc-One	48 mg/6 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time Patient to use: ☐ unilaterally ☐ bilaterally ☐ Supplies: Include one 20G 1.5" needle per syringe	Quantity: _____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute
Prescriber's Signature: _____ **Date:** _____

May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.