

Osteoarthritis Enrollment Form



Fax Referral To: 1-800-323-2445

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-800-237-2767

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):

- | | |
|--|--|
| <input type="checkbox"/> M17.0 Bilateral primary OA of knee | <input type="checkbox"/> M17.10 Unilateral primary OA, unspecified knee |
| <input type="checkbox"/> M17.11 Unilateral primary OA, right knee | <input type="checkbox"/> M17.12 Unilateral primary OA, left knee |
| <input type="checkbox"/> M17.2 Bilateral post-traumatic OA of knee | <input type="checkbox"/> M17.30 Unilateral post-traumatic OA, unspecified knee |
| <input type="checkbox"/> M17.31 Unilateral post-traumatic OA, right knee | <input type="checkbox"/> M17.32 Unilateral post-traumatic OA, left knee |
| <input type="checkbox"/> M17.4 Other bilateral secondary OA of knee | <input type="checkbox"/> M17.5 Other unilateral secondary OA of knee |
| <input type="checkbox"/> M17.9 OA of knee, unspecified | <input type="checkbox"/> 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
<input type="checkbox"/> Gel-One	30 mg/3 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe	Quantity: _____
<input type="checkbox"/> Synvisc	16 mg/2 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly once a week for 3 weeks Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally <input type="checkbox"/> Supplies: Include one 20G 1.5" needle per syringe	Quantity: _____
<input type="checkbox"/> Synvisc-One	48 mg/6 mL prefilled syringe	Inject contents of prefilled syringe intra-articularly one time Patient to use: <input type="checkbox"/> unilaterally <input type="checkbox"/> bilaterally <input type="checkbox"/> 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.