Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy

Clear Form

AccuSERV® PHARMACY

Osteoarthritis Enrollment Form

Fax: (877) 526-8823

Pharmacy Phone: (866) 213-9821

Single Point of Contact: (724) 515-7053

1. Patient Information

Start Date:_____ **Ship to:** ☐ Patient ☐ Office _____ Other

Patient Name: _____ ◯Male◯Female DOB:_____

Address: _____

Soc. Sec. # _____ Phone #:_____ Alt Phone #:_____

Caregiver:_____ Allergies: _____

Comorbidities: _____ Height: _____ Weight: _____

2. Clinical Information

Please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization

ICD -10/ Diagnosis Code:_____ TB Test:◯yes◯no Date of Negative Result: _____

Prior Therapies:_____ Affected Area (s):_____

3. Prescription Information

If your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided

✘	Medication	Dose / Strength	Directions (be specific)	Quantity	Refills
☐	Euflexxa®	◯ 1% (2mL PFS)	◯ inject 1 time per week for 3 weeks	◯3 PFS	
☐	Gel-One®	◯ 30mg/3mL (3mL PFS)	◯ inject 3mL intra-articularly	◯ 1 PFS	
☐	Hyalgan®	◯ H-220 (20mg/2mL PFS) ◯ H-212 (2mL vial)	◯ inject 1 time per week for 3 weeks ◯ inject 1 time per week for 5 weeks ◯	◯ 1 PFS ◯ 1 vial ◯	
☐	Hymovis®	◯ 24mg/3mL (6mL PFS)	◯ inject intra-articularly as directed	_____ PFS	
☐	Monovisc®	◯ 88mg/ 4 mL PFS	◯ inject 4 mL intra-articularly one time	◯ 1 PFS	
☐	Orthovisc®	◯ 15mg/mL (2mL PFS)	◯ inject 1 time per week for 3 weeks ◯ inject 1 time per week for 4 weeks	◯ 1 PFS ◯	
☐	Supartz Fx®	◯ 10mg/ mL (2.5mL PFS)	◯ inject _____mL intra-articularly once a wk for_____ wks	_____ PFS	
☐	Synvisc®	◯ Hylan G-F 20 (2mL PFS)	◯ inject 1 time per week for 3 weeks	◯ 3 PFS	
☐	Synvisc One®	◯ Hylan G-F (6mL PFS)	◯ inject 6mL intra-articularly into affected knee	◯ 1 PFS	
☐	Vimovo®	◯375-20mg ◯500-20mg	◯ take 1 tablet twice a day, 30 min before meal	◯60 tablets	
☐					

4. Prescriber and Shipping Information

Prescriber (print) : _____ Office Contact: _____

Pref. Method of Contact: ◯phone ◯fax ◯email Contact email:_____

Office Address: _____

Phone: _____ Fax:_____

NPI: _____ DEA: _____

Prescriber's Signature: _____ Date:_____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information

Please fax a copy of insurance card front and back. Enlarge if possible.

Please fax completed form to AccuServ Pharmacy at (877) 526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.