HYMOVIS® Reimbursement and Patient Assistance
PO Box 5817, Louisville, KY 40255-0817
Phone: (866) 749-2542
Fax: (877) 366-0584
Program Hours: Monday – Friday 9am – 8pm EST

HYMOVIS® BENEFITS INVESTIGATION

**Please complete the application in its entirety.

Fax the completed application to: (877) 366-0584 — The Physician **must** sign the application.

Please Check All That Apply ☐**Physician Buy/Bill** ☐ **If Buy/Bill is unavailable please submit to the Specialty Pharmacy** ☐**Fulfill Through Specialty Pharmacy Only**

Patient Information (required for all requested services) — **OK to contact Patient** ☐

First Name: | Last Name:

Address: | City: | State: | Zip:

Phone Number: | Gender: ☐Male ☐Female | Date of Birth: | SS#:

Primary Insurance (required for Benefit Investigation and Triage to SPP only)

- **Please copy and attach Patient's insurance cards**

Name: | Policy #: | Group #:

Subscriber's Name: | Date of Birth: | Address:

City: | State: | Zip:

Secondary Insurance (required for Benefit Investigation and Triage to SPP only)

Name: | Policy #: | Group #:

Subscriber's Name: | Date of Birth: | Address:

City: | State: | Zip:

Therapy and Diagnosis Information (required for all requested services)

Injection Site: ☐Right Knee ☐Left Knee ☐Bilateral

Product HYMOVIS 24mg/ 3ml
Sig: Administer by intra-articular injection as directed

Dose: ☐ 2 Syringes ☐ 4 Syringes

Allergies:

Does the patient have a failure, contraindication, or intolerance to the following treatment options? (Check all that apply)
☐Non – pharmacologic (e.g. exercise, physical therapy, weight loss if overweight) ☐Intra-articular corticosteroids
☐Non- steroidal anti-inflammatory medications (e.g. ibuprofen) ☐Non- narcotic analgesics (e.g. acetaminophen)

Does the individual have documented symptomatic osteoarthritis of the knee? ☐Yes ☐ No

Has the patient tried any other medications for this condition? ☐Yes (if yes, please complete below) ☐ No
Medication/Therapy_____ Duration of Therapy_____
Response/Reason for Failure_____

Primary Diagnosis: ☐ M17.0 ☐M17.2 ☐ M17.9 ☐M17.10 ☐M17.11 ☐M17.12 ☐M17.30 ☐M17.31 ☐M17.32 ☐ Other M:_____

Prescriber Information (product will be shipped to Prescriber's address below)

First Name: | Last Name: | Specialty: | Site Name:

Address: | City: | State: | Zip:

Phone No. | Fax No.

NPI#: | Tax ID: | State License Number:

Office Contact Name: | Contact Phone Number:

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Hymovis® (High Molecular Weight Viscoelastic Hyaluronan) based on my professional judgment of medical necessity. I authorize Fidia Pharma USA Inc. and its representatives and agents through the Hymovis® Reimbursement Program ("the "Program") to investigate insurance coverage and information and any other Program-related services that I may request for the above name patient. I have a signed copy on file of my patient's current and completed HIPAA Authorization Form so that I may share patient health with the Program. I authorize HUB to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. State-required statement: 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

Prescriber Signature: Prescriber must manually sign the appropriate section on how to dispense

X		X	
Dispense as written	**Date**	**Substitution permitted**	**Date**