

HYMOVIS[®] BENEFITS INVESTIGATION

**Please complete the application in its entirety.

Fax the completed application to: (877) 447-9734		The Physician must sign the application.	
Please Check All That Apply <input type="checkbox"/> Physician Buy/Bill <input type="checkbox"/> Fulfill Through Specialty Pharmacy Only <input type="checkbox"/> Claim Assistance <input type="checkbox"/> If Buy/Bill is unavailable please submit to the Specialty Pharmacy			
Patient Information (required for all requested services)			OK to contact Patient <input type="checkbox"/>
First Name:		Last Name:	
Address:		City:	State: Zip:
Phone Number:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Bilateral		Product HYMOVIS 24mg/ 3ml Sig: Administer by intra-articular injection as directed	
Dose: <input type="checkbox"/> 2 Syringes <input type="checkbox"/> 4 Syringes		Allergies:	
Does the patient have a failure, contraindication, or intolerance to the following treatment options? (Check all that apply)			
<input type="checkbox"/> Non – pharmacologic (e.g. exercise, physical therapy, weight loss if overweight) <input type="checkbox"/> Intra-articular corticosteroids <input type="checkbox"/> Non- steroidal anti-inflammatory medications (e.g. ibuprofen) <input type="checkbox"/> Non- narcotic analgesics (e.g. acetaminophen)			
Does the individual have documented symptomatic osteoarthritis of the knee? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has the patient tried any other medications for this condition? <input type="checkbox"/> Yes (if yes, please complete below) <input type="checkbox"/> No Medication/Therapy _____ Duration of Therapy _____ Response/Reason for Failure _____	
Primary Diagnosis: <input type="checkbox"/> M17.0 <input type="checkbox"/> M17.2 <input type="checkbox"/> M17.9 <input type="checkbox"/> M17.10 <input type="checkbox"/> M17.11 <input type="checkbox"/> M17.12 <input type="checkbox"/> M17.30 <input type="checkbox"/> M17.31 <input type="checkbox"/> M17.32 <input type="checkbox"/> Other M: _____			
Prescriber Information (product will be shipped to Prescriber's address below)			
First Name:		Last 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