CenterWell Specialty Pharmacy

Fax: 877-405-7940
Phone: 800-486-2668

CenterWell Specialty Pharmacy™

Monday – Friday: 8 a.m. – 11 p.m., and
Saturday: 8 a.m. – 6:30 p.m., Eastern time

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Viscosupplement Prescription Form

Patient information

Patient: ________________________ ❒ Female ❒ Male DOB: __________ Insurance plan: ________________ Plan ID #: ___________

Address: ____ City: _________________________ State: _____ ZIP code: ___________

Home phone #: _______________ Cell phone #: _______________ Caregiver: __________________ Caregiver phone #: ______________

Other medical conditions: _____________________________ Allergies: ❒ NKDA ❒ Yes: ____

Height: ________ Weight: _______ ❒ lb ❒ kg Date: ___________

Clinical information

ICD-10 code: __________________________ Diagnosis: ____ Diagnosis date: _______________

Concurrent medications: ____

Expected date of first or next injection: _________________

If applicable, please provide each previous therapy and its dates:

Therapy:	Discontinuation reason:	Dates:
❒ ________________________________	____	_______________
❒ ________________________________	____	_______________
❒ ________________________________	____	_______________

Prescription information

Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication

❒ Durolane	20 mg/mL	3 mL PFS	❒ Hymovis	8 mg/mL	3 mL PFS	❒ Synvisc	8 mg/mL	2 mL PFS
❒ Euflexxa	10 mg/mL	2 mL PFS	❒ Monovisc	22 mg/mL	4 mL PFS	❒ Synvisc-One	8 mg/mL	6 mL PFS
❒ Gel-One	10 mg/mL	3 mL PFS	❒ Orthovisc	15 mg/mL	2 mL PFS	❒ Triluron	10 mg/mL	2 mL PFS
❒ Gelsyn-3	8.4 mg/mL	2 mL PFS	❒ sodium hyaluronate	10 mg/mL	2 mL PFS	❒ TriVisc	10 mg/mL	2.5 mL PFS
❒ GenVisc 850	10 mg/mL	2.5 mL PFS	❒ Supartz FX	10 mg/mL	2.5 mL PFS	❒ Visco-3	10 mg/mL	2.5 mL PFS
❒ Hyalgan	10 mg/mL	2 mL PFS						
❒ Hyalgan	10 mg/mL	2 mL vial						

Knee	Directions	Quantity	Refills
❒ Left ❒ Right ❒ Bilateral	____ ____	❒ _____ syringes ❒ _____ vials	_____

Prescriber and shipping information (please print)

Prescriber: ____ NPI: ____________________________________

Ship to: ❒ Patient ❒ Office ❒ Other: ____

Office address: ____ City: ___________________________ State: _____ ZIP code:__________

Office phone number: __________________________ Office fax number: __________________________

Signature: ____ Date: ________________

We will dispense this prescription as generic, unless the prescriber indicates “Dispense as Written” here: ________________________

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.