Hymovis® HYADD®4 High Molecular Weight Viscoelastic Hyaluronan

fidiacomplete

Phone: (866) 496-6847 Fax: 877-447-9734
www.fidiacomplete.com

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 One That Applies ☐ **Buy/Bill, if unavailable please submit to the Specialty Pharmacy** ☐ **Fulfill Through Specialty Pharmacy Only** ☐ **Claim Assistance**

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 information 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**