Fax: 877-405-7940
Phone: 800-486-2668
NPI: 1942441886

CenterWell Specialty Pharmacy™

Mon-Fri, 8 a.m. – 11 p.m. & Sat 8 a.m. – 6:30 p.m. EST

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with a 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: _____

Primary ph #: _____ Secondary ph #: _____ Caregiver: _____ Caregiver ph #: _____

Other medical conditions: _____ Allergies: ❒ NKDA ❒ Yes: _____

Height: _____ Weight: _____ ❒ lbs ❒ 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.