GenVisc850 — 5 injection hyaluronic acid regimen

TriVisc — 3 injection hyaluronic acid regimen

AVANOS | orthogenx

HarmoKnee.support
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PATIENT BENEFIT & PRESCRIPTION ENROLLMENT FORM

PATIENT INFORMATION		
*Patient Name (Last, First):		
*Date of Birth:	*Gender: M F	
*Address:		
*City	*State	*Zip
Email:		
Home Phone:	Ok to leave message ☐ Yes ☐ No	
Cell Phone	Ok to leave message ☐ Yes ☐ No	

PRIMARY MEDICAL INSURANCE	
*Benefit/Cardholder Name:	
*Primary Insurance:	*Phone:
*Member ID	*Group ID:

SECONDARY MEDICAL INSURANCE	
Secondary Insurance:	Phone:
Member ID	Group ID:

PRESCRIPTION INSURANCE	
Bin:	PCN:
Group ID:	ID #:

PRESCRIBER INFORMATION		
*Prescriber Name (Last, First):		
*Practice Name:		*NPI
*Prescriber Phone:	Fax:	
*Prescriber Address:		
*City	*State	*Zip
Email:	Practice Specialty:	
*Tax ID	PTAN:	
Office Contact Name:		

STATEMENT OF MEDICAL NECESSITY AND PHYSICAL AUTHORIZATION

**Please attach clinical documentation.

☐ **GenVisc*850 sodium hyaluronate**
Per Package Insert - Inject once weekly for a maximum of 5 injections

☐ **TriVisc* sodium hyaluronate**
Per Package Insert - Inject once weekly for a maximum of 3 injections

Other Sig: _____

Dose:25mg/2.5ML Quantity

☐ 3 syringes ☐ 5 syringes (Genvisc 850 only)

☐ Other (Please indicate) ____

Allergies:

Instructions:

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?
☐ No ☐ Yes (if yes, please complete below)
Medication/Therapy
Duration of Therapy
Response/Reason of Failure

Does the patient have a documented or suspected intolerance or allergy to avian proteins including chicken, turkey, feathers or egg containing products? ☐ Yes ☐ No

Primary Diagnosis (ICD-10):

Administration (CPT):

By signing below, I certify that (1) the above therapy is medically necessary and in the best interest of the patient; (2) the information provided is complete and accurate to the best of my knowledge; (3) I have obtained all necessary Federal and state authorizations and consents from my patient to allow 'HarmoKnee Reimbursement Solutions' ("Program") and/or other companies, or its subcontractors to assist with benefits verification, prior authorization, appeals assistance, and forwarding the above prescription to a dispensing pharmacy; and [4] I agree to the Business Associate Agreement as presented at https://baa.harmoknee.support/

*Physician Signature

*Date of Signature

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