AVANOS | orthogenrx

HarmoKnee.support
P: (866) 556-2259
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CPL-AVAPAP#
Case Id:

PATIENT ASSISTANCE PROGRAM APPLICATION AND PRESCRIPTION FORM

Patient Information

First Name:	Last Name:		
Address:	City:	State:	Zip:
Phone Number:	Gender:	Date of Birth:	
Is the above patient uninsured? Yes No	Insurance Provider: If a denial has already been received, please submit that information with this form.		
Please indicate any allergies:	Health conditions:	Other medications:	

Prescriber Shipping Address (Product will be shipped to HCP office for use on patient)

First Name:	Last Name:		
Practice Name:		NPI:	
Office Address:	City:	State:	Zip:
Office Phone:	Office Fax:	Office Email:	

Patient Assistance Program Eligibility

- Patient must be 22 years of age or older and have a valid prescription.
- Patient must be a US citizen or legal resident in U.S. Territories.
- Patient's total household income must be at or below 300% of the Federal Poverty Level
- Patient must have no insurance, is underinsured and/or does not have a medical or pharmacy benefit to pay for the Avanos Medication
- This request must be completed and accompanied by a copy of one of the following documents:
  - Previous year's federal tax return (form 1040 or 1040EZ)
  - Wage and tax statements (W-2 forms)
  - Two recent paycheck stubs
  - Social security, pension, or retirement statements (SSA-1099 or similar)
  - Patient will notify their insurance plan that they are receiving product outside their plan

Prescription (One time fill - Refill would require new Rx)

GenVisc850 (5 injection hyaluronic acid regimen)	**Unilateral Qty.** **5 Syringes**	**Bilateral Qty.** **10 Syringes**	**Other Qty.** **__ Syringes**
TriVisc (3 injection hyaluronic acid regimen)	**Unilateral Qty.** **3 Syringes**	**Bilateral Qty.** **6 Syringes**	**Other Qty.** **__ Syringes**

Dose: Inject 25 mg (2.5mL) intra-articularly once weekly. Injection of subcutaneous lidocaine or similar local anesthetic may be recommended prior to injection.
Each box contains one (1) sterile, pre-filled syringe (1 regimen/dose)

I understand and certify the above medication is intended for my patient's treatment, and no units of this product will be submitted for Medicare, Medicaid or any public or private third-party reimbursement, or returned for credit. I will not bill this Patient or any government program or commercial payer for the Patient Assistance Product, injecting the Patient Assistance Product, or other services necessary to the administration of the Patient Assistance Product. I understand eligibility under this program is subject to 'HarmoKnee Reimbursement Solutions' ("Program") approval and the patient's continuing compliance with all eligibility requirements, as set by Avanos Medical, Inc. I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release medical and/or other companies, or its subcontractors to forward this prescription to a dispensing pharmacy. GenVisc*850 and TriVisc* are indicated for the treatment of pain in osteoarthritis (OA) of the knee in patients who have failed to respond adequately to conservative non-pharmacologic therapy and simple analgesics, e.g., acetaminophen. Do not administer to patients with known hypersensitivity (allergy) to sodium hyaluronate preparations. Do not inject GenVisc*850 and TriVisc* in the knees of patients with infections or skin diseases in the area of the injection site. Full prescribing information can be found in product labeling, at www.avanos.com. *Any additional prescription requirements required by state law, such as NY's Pharmacy eRX/Rx attachment law.
I attest, by signing below, that the information I am providing is truthful and accurate.

Prescriber Signature:	Date:

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