



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 Sp Fulfill Through Specialty Pharmacy Only			• •	cialty Pharmacy		
Patient Information (required for all requested services)				OK to contact Patient		
First Name: Last Name:						
Address:			City:	State: Zip	:	
Phone Number:	Ge	nder: Male F	Female Date of	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:	Da	te of Birth:	Address:			
City:	City: State:				Zip:	
Secondary Insurance (required for Benefit Investigation and Triage to SPP only)						
Name:				Policy #:	Group #:	
Subscriber's Name:	Da	te of Birth:	Address:			
City:		State:		Zip:		
Therapy and Diagnosis Information (required for all requested services)						
Injection Site: Right Knee Left Knee Bilateral 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) □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	Medication/T	Has the patient tried any other medications for this condition? Yes (if yes, please complete below) No Medication/Therapy Response/Reason for Failure				
Primary Diagnosis:	И17.2 ПМ17.9	□M17.10 □M	17.11	M17.30	Other M:	
Prescriber Information (product will be shipped to Prescriber's address below)						
First Name:	st Name: Last Name:			Site Name:		
Address: City:			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						
Х			x			
Dispense as written		Date	Substitution perr	nitted	Date	