euflexxa® 1% SODIUM HYALURONATE

Reimbursement & Pharmacy Support
Patient Enrollment & Prescription Form

Phone: 1-866-EUFLEX1 (1-866-383-5391)
Fax: 1-866-EUFLEX2 (1-866-383-5392)
www.euflexxaonline.com

Patient Information

Last Name	First Name	SSN	DOB
Home Address	City	State	Zip
Home Phone	Alt Phone	Gender ☐ Female ☐ Male	

Medical Insurance - Primary

Plan Name	Phone #
Member ID	Group #

Medical Insurance - Secondary

Plan Name	Phone #
Member ID	Group #

Pharmacy Insurance - Primary

Member ID	BIN
PCN	Group #

Pharmacy Insurance - Secondary

Member ID	BIN
PCN	Group #

Physician Information

Full Name	NPI	Tax ID		License	PTAN
Address	City	St	Zip	Phone	Fax

Requested Investigation

☐ Run Medical Benefits Investigation in order to Buy & Bill
☐ Run Pharmacy Benefits Investigation and script medication through the Pharmacy
☐ Complete Benefits Investigation for both Pharmacy and Medical Benefit (Recommended)

CPT Code (Choose Administration):
☐ 20610 - Intra-articular Injection
☐ 20611 - Ultrasound-Guided Intra-articular Inj.

Please note that Prior Authorizations will not be completed for Medical Benefits Investigations. It is the responsibility of the provider to complete this process after the patient benefits have been determined. If no benefits investigation option is selected, both medical and pharmacy benefits investigations will be conducted for CPT Code 20610. Benefits given are an estimation and not a guarantee of payment. Benefits are subject to change, and it is recommended that benefits are obtained within two weeks of the intended date of service to assure accuracy of plan information.

Clinical Information

ICD Code(s): Check primary code
☐ _____
☐ _____

Treatment Site(s):
☐ Right Knee ☐ Left Knee ☐ Bilateral

Scheduled Date of Treatment:

Prior Treatments:
Has the patient received prior HA treatments? ☐ Yes ☐ No
Site(s) previously treated ☐ Right Knee ☐ Left Knee ☐ Bilateral
Date(s) of prior treatments: _____
Product(s) used: _____

Prescription Information (Choose dosing):

☐ **Unilateral**

euflexxa® 1% SODIUM HYALURONATE

Directions:
Inject 1 Euflexxa syringe into the affected knee weekly for 3 weeks.

Quantity: 3

☐ **Bilateral**

euflexxa® 1% SODIUM HYALURONATE

Directions:
Inject 1 Euflexxa syringe into each knee weekly for 3 weeks.

Quantity: 6

☐ If you would like to proceed by having Euflexxa automatically scripted through the Specialty Pharmacy Channel, please check here. This alleviates you and your office form having to call in and give verbal authorization. Upon checking the box and submitting, the script will begin to be processed and dispensed to the physician's address on file.

PRESCRIBER'S SIGNATURE REQUIRED[1]

MD / NP / PA Signature: _____

[1]Authorization for Release of Health Information: By signing this form, I represent to The Euflexxa Solution Center that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release health information to The Euflexxa Solution Center and its contracted third parties. I authorize The Euflexxa Solution Center 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. Signature on this form also provides consent to contact this patient's insurance provider for this prescription on the prescriber's behalf.