

CAREMARK ENROLLMENT FORM

OSTEOARTHRITIS

Section 1 should be completed by the patient. Section 2 should be completed by the physician and staff.
Section 3 provides the fax number to send the completed form to.

CAREMARKCONNECT®

TEL (800) 237-2767

FAX (800) 323-2445

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PATIENT INFORMATION

Last Name	First Name	Middle Initial	
Street Address	City	State	Zip Code
Day Telephone (+Area Code)	Night Telephone (+Area Code)	<input type="checkbox"/> M <input type="checkbox"/> F	
Date of Birth	Social Security Number	Sex (✓One)	

INSURANCE INFORMATION

Pharmacy Insurance Card	Medical Insurance Card
Cardholder Name & Social Security Number (If Not Patient)	Cardholder Name & Social Security Number (If Not Patient)
Group/Policy Number	Group/Policy Number
Insurance Telephone Number (+Area Code)	Insurance Telephone Number (+Area Code)
Employer	Medicaid Number

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law. In signing below, you indicate and acknowledge that the information you provided above is true and correct.

Patient Signature: _____ Date: _____

CAREMARK Thank you for choosing Caremark!
It all starts with care™

PHC3501-061504BL

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PHYSICIAN INFORMATION

Prescriber's Name	Hospital/Clinic	Office Contact
Address	City/State/Zip	Telephone Number (+Area Code)
Prescriber's License Number	DEA Number	Fax Number (+Area Code)
Supervising Physician's Name (If Required for Mid-Level Practitioner)	License Number	

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: (ICD-9 CM Code Plus Description)

- 715.0 Osteoarthritis
 Other _____

Does the patient have knee joint infection or skin disease/infection in the area of the injection site? Yes No

Has the patient been treated with simple analgesics in the past? Yes No

Name of analgesic _____ Length of treatment _____

Rx

Patient Weight: _____ kg. OR _____ lbs.	Drug Allergies _____ <input type="checkbox"/> NKDA
<input type="checkbox"/> Hyalgan® 20mg/2.0ml <input type="checkbox"/> 20mg Every week for 5 weeks Qty: _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Synvisc® 16mg (Hylan A + Hylan B)/2.0ml <input type="checkbox"/> 16mg Every week for 3 weeks Qty: _____ <input type="checkbox"/> Other _____
<input type="checkbox"/> Supartz® 25mg/2.5ml <input type="checkbox"/> 25mg Every week for 5 weeks Qty: _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Ancillary supplies as needed for injection are included.

Other Prescriber's Notes:

Refill: 12 months Refill _____ times
 Dispense As Written Substitution Allowed

Prescriber's Signature: _____

Physician's Signature (If required for Medical Necessity)

Date: Unless otherwise indicated, date used will be date of fax transmission.

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FAX COMPLETED FORM TO CAREMARKCONNECT® AT 1 (800) 323-2445

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.