aetna®

Viscosupplementation Medication Request

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809
www.AetnaSpecialtyPharmacy.com

Customer Service: 1-866-782-ASRX (1-866-782-2779) **Fax Order Submission: 1-866-FAX-ASRX (1-866-329-2779)**

For your convenience, this medication request may be submitted via E-PRESCRIBE to Aetna Specialty Pharmacy

Aetna Specialty Pharmacy will verify benefits and contact members to confirm delivery before medication is shipped.

Today's Date: **Date Needed:**

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Weight:	Height:	Allergies:	

B. INSURANCE INFORMATION

Carrier Name: _____
Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes Carrier Name: _____
Member ID#: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:	Last Name: *(Check One):* ☐ MD ☐ DO ☐ NP ☐ PA		
Address:	City:	State:	ZIP:
Phone: Fax:	DEA #: NPI #:	Office Contact:	

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's provider precertification list to verify precertification requirements.

Medication	Directions	Quantity
☐ DUROLANE	☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other joint: _____ ☐ One time injection ☐ Other:	☐ 1 dose ☐ 2 doses ☐ Other:
☐ EUFLEXXA	☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other joint: _____ ☐ Inject once weekly for 3 weeks ☐ Other:	☐ 1 box (3 doses) ☐ 2 boxes (6 doses) ☐ Other:
☐ GEL-ONE	☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other joint: _____ ☐ One time injection ☐ Other:	☐ 1 dose ☐ 2 doses ☐ Other:
☐ GELSYN-3	☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other joint: _____ ☐ Inject once weekly for 3 weeks ☐ Other:	☐ 3 doses ☐ 6 doses ☐ Other:
☐ GENVISC 850	☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other joint: _____ ☐ Inject once weekly for 3 weeks ☐ Inject once weekly for 4 weeks ☐ Inject once weekly for 5 weeks ☐ Other:	☐ 3 doses ☐ 6 doses ☐ 4 doses ☐ 8 doses ☐ 5 doses ☐ 10 doses ☐ Other:
☐ HYALGAN	☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other joint: _____ ☐ Inject once weekly for 3 weeks ☐ Inject once weekly for 4 weeks ☐ Inject once weekly for 5 weeks ☐ Other:	☐ 3 doses ☐ 6 doses ☐ 4 doses ☐ 8 doses ☐ 5 doses ☐ 10 doses ☐ Other:
☐ HYMOVIS	☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other joint: _____ ☐ Inject once weekly for 2 weeks ☐ Other:	☐ 1 box (2 doses) ☐ 2 boxes (4 doses) ☐ Other:

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

*Interchange is mandated unless practitioner handwrites the words **"MEDICALLY NECESSARY"** for each medication.*

Prescriber's Signature **(Required by Law):**

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A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Weight:	Height:	Allergies:	

B. INSURANCE INFORMATION

Carrier Name: _____
Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes Carrier Name: _____
Member ID#: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid:** ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:	Last Name: *(Check One):* ☐ MD ☐ DO ☐ NP ☐ PA		
Address:	City:	State:	ZIP:
Phone: / Fax:	DEA #: / NPI #:	Office Contact:	

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's provider precertification list to verify precertification requirements.

Medication	Directions	Quantity
☐ MONOVISC	☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other joint: _____ ☐ One time injection ☐ Other:	☐ 1 dose ☐ 2 doses ☐ Other:
☐ ORTHOVISC	☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other joint: _____ ☐ Inject once weekly for 3 weeks ☐ Inject once weekly for 4 weeks ☐ Other:	☐ 3 doses ☐ 6 doses ☐ 4 doses ☐ 8 doses ☐ Other:
☐ SUPARTZ FX	☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other joint: _____ ☐ Inject once weekly for 3 weeks ☐ Inject once weekly for 4 weeks ☐ Inject once weekly for 5 weeks ☐ Other:	☐ 3 doses ☐ 6 doses ☐ 4 doses ☐ 8 doses ☐ 5 doses ☐ 10 doses ☐ Other:
☐ SYNVISC	☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other joint: _____ ☐ Inject once weekly for 3 weeks ☐ Other:	☐ 1 box (3 doses) ☐ 2 boxes (6 doses) ☐ Other:
☐ SYNVISC-ONE	☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other joint: _____ ☐ One time injection ☐ Other:	☐ 1 dose ☐ 2 doses ☐ Other:
☐ Other:		

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

*Interchange is mandated unless practitioner handwrites the words **"MEDICALLY NECESSARY"** for each medication.*

Prescriber's Signature **(Required by Law):**

Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. This pharmacy is a for-profit entity.