TRILURON® sodium hyaluronate

fidiacomplete

Phone: 1-866-749-2542, Option 2 **Fax:** 877-447-9734
www.fidiacomplete.com

TRILURON® 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 Specialty Pharmacy** ☑ **Fulfill Through Specialty Pharmacy Only**	☐ **Claim Assistance**

Patient Information (required for all requested services) — **OK** to contact Patient ☐

First Name:		Last Name:	
Address:		City:	State: Zip:
Phone Number:	Gender: ☐ Male ☐ Female	Date 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:	Date of Birth:	Address:
City:	State:	Zip:

Secondary Insurance (required for Benefit Investigation and Triage to SPP only)

Name:	Policy #:	Group #:
Subscriber's Name:	Date of Birth:	Address:
City:	State:	Zip:

Therapy and Diagnosis Information (required for all requested services)

Injection Site: ☐ Right Knee ☐ Left Knee ☐ Bilateral	**Product TRILURON® 20mg/2mL** Sig: Administer by intra-articular injection as directed
Dose: ☐ 3 Syringes ☑ 6 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) ☐ Intra-articular corticosteroids
☐ 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	Has the patient tried any other medications for this condition? ☐ Yes (if yes, please complete below) ☐ No Medication/Therapy_____ Duration of Therapy_____ Response/Reason for Failure_____

Primary Diagnosis: ☐ M17.0 ☐ M17.2 ☐ M17.9 ☐ M17.10 ☐ M17.11 ☐ M17.12 ☐ M17.30 ☐ M17.31 ☐ M17.32 ☐ Other M:_____

Prescriber Information (product will be shipped to Prescriber's address below)

First Name:	Last Name:	Specialty:	Site Name:
Address:		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 TRILURON® based on my professional judgment of medical necessity. I authorize Fidia Pharma USA Inc. and its representatives and agents through the TRILURON® Reimbursement Program ("the "Program") to investigate insurance coverage and information and any other Programrelated 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 eprescribing, 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

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X		**X**	
Dispense as written	**Date**	**Substitution permitted**	**Date**