HYALGAN®
(sodium hyaluronate)

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

HYALGAN® BENEFITS INVESTIGATION AND PATIENT ASSISTANCE PROGRAM

**Please complete the application in its entirety.

Fax the completed application to: (877) 447-9734 — The Physician **must** sign the application.

Please Check All That Apply ☐ **Buy/Bill, if unavailable please submit to the Specialty Pharmacy** ☐ **Claim Assistance**
☐ **Fulfill Through Specialty Pharmacy Only**

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 — **Triage to Specialty Pharmacy** ☐

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 HYALGAN 20mg/2ml** Sig: Administer by intra-articular injection as directed	
Dose: ☐ 3 ☐ 5 ☐ Other (Please Indicate):	**Dose:** ☐ Vial ☐ Syringe	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 Hyalgan® (sodium hyaluronate) based on my professional judgment of medical necessity. I authorize Fidia Pharma USA Inc. and its representatives and agents through the Hyalgan® Reimbursement and Patient Assistance Program ("the "Program") to investigate insurance coverage and information and any other Program-related services that I may request for the above name patient. If the patient has limited or does not have any public or private insurance coverage for Hyalgan® and meets the required income and other criteria set by Fidia Pharma USA Inc. I understand that this patient may be eligible for participation in patient assistance through the Program. If I become aware of a change in income or insurance status that may affect my patient's participation in the Program, I will alert the Program of these changes. I understand that Fidia Pharma USA Inc. could ask for a copy of this patient's IRS 1040 form or other proof of income for purposes of audit. My signature certifies that any patient assistance products received from the Program will be used for the above named patient only and will not be resold or offered for sale, trade or barter, will not be submitted for reimbursement from any public or private insurance company and will not be returned for credit. I have a signed copy on file of my patient's current and completed HIPAA Authorization Form so that I may share patient health 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

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

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Patient Assistance Instructions:
- Please complete the application in its entirety including the prescription section.
- The Patient must sign the **Patient Certification and Authorization to Disclose Information** section.
- The Physician must sign the application.
- **Fax the application with financial documentation to:** (877) 447-9734

Patient Assistance Program Eligibility:
- Patients insured by a government program are not eligible for the Patient Assistance Program
- Patient must be a legal resident of the 50 United States or District of Columbia.
- Patient cannot have, or qualify for, any healthcare insurance coverage for HYALGAN®.
- Patient's total yearly household income must be at or below the limits shown in the chart below.

Financial Information (All values should include the yearly amounts of entire household)
- Total Gross Yearly Income $ _____________
- Household Size: ________________________ (Number of people who contribute to or are dependent on your household)
- Valid form of ID with proof of date of birth
- Copy of W2 or two most recent pay stubs

SOURCE: http://aspe.hhs.gov/poverty/

2021 Poverty Guidelines for:	48 Contiguous States and the District of Columbia	**Alaska**	**Hawaii**
Persons in family/household	250% Poverty Guideline	250% Poverty Guideline	250% Poverty Guideline
1	$32,200	$40,225	$37,050
2	$43,550	$54,425	$50,100
3	$54,900	$68,625	$63,150
4	$66,250	$82,825	$76,200
5	$77,600	$97,025	$89,250
6	$88,950	$111,225	$102,300
7	$100,300	$125,425	$115,350
8	$111,650	$139,625	$128,400
9+	Add $11,350 for each additional person	Add $14,200 for each additional person	Add $13,050 for each additional person

Patient Assistance (Required for Patient Assistance Services only)

Does the patient have or qualify for government funded healthcare coverage for HYALGAN®? ☐ Yes ☐ No

Does this patient have any private insurance for HYALGAN? ☐ Yes ☐ No	Is patient a legal U.S. resident? ☐ Yes ☐ No
How many people are in the patient's household?	What is the total ANNUAL household income? $

Patient Certification and Authorization to Disclose Information:
The information you provide will be used by Fidia Pharma USA Inc. ("Fidia"), the HYALGAN® Reimbursement and Patient Assistance Program "Program"), and parties acting on their behalf to determine eligibility, to manage and improve the Program, products and services, and/or to communicate with you about your experience with the Program. By signing below, I affirm that my answers and my proof-of-income documents are complete, true and accurate to the best of my knowledge and I give the Program, and Program administrators, permission to contact my legal guardian (if applicable) with follow up questions about my application.

I understand that:
- Completing this enrollment form does not guarantee that I will qualify for the Program.
- Fidia may verify the accuracy of the information I have provided and may ask for more financial and insurance information.
- Any products supplied by the Program shall not be sold, traded, bartered or transferred.
- Fidia reserves the right to change or cancel the Program, or terminate my enrollment, at any time.
- I can withdraw from the Program at any time and cancel my permission to use my information.
- The support provided in this Program is not contingent on any future purchase.

I certify and attest that if I receive product(s) provided by Fidia through the Program:
- I will promptly contact the Program if my financial status or insurance coverage changes.
- I will not seek to have this product or any cost from it counted in my Medicare Part D out-of-pocket expenses for prescription products.
- I will not seek reimbursement or credit for the product(s) from my prescription insurance provider or payor, including Medicare Part D plans for any costs of products.
- I will notify my insurance provider of the receipt of any products through the Program.

I have a signed copy of a current and completed HIPAA Authorization Form on record with my Prescriber so that my Prescriber may share health information about me with the Program, Fidia and any third parties responsible for administering the Program.

Patient Signature:	**Date**