FlexForward® Prescription & Enrollment Form

Fax completed enrollment form to 1-866-558-7939

Call us at 1-844-353-9466,
Monday - Friday, 8 AM - 8 PM ET

Fax us the completed enrollment form
at 1-866-558-7939

Note: Fields marked with * are required.

1. Patient Information

Last name*: _____ First name*: _____
Address*: _____ City*: _____ State*: _____ ZIP*: _____
Cell phone #: _____ Home phone #: _____ Email: _____
Gender*: ❑ Male ❑ Female Date of birth*: _____/_____/_____ Preferred time to contact: ❑ AM ❑ PM

2. Prescriber Information

Last name*: _____ First name*: _____
NPI #*: _____ State license #: _____ Tax ID #: _____ DEA #: _____
Office name: _____
Address*: _____ City*: _____ State*: _____ ZIP*: _____
Phone #*: _____ Fax #*: _____

Primary Contact

Last name: _____ First name: _____ Title: _____
Email: _____ Phone #: _____ Fax #: _____
Preferred method of contact: ❑ Phone ❑ FlexForward Portal

3. Insurance Information

❑ **Patient is uninsured**

Attach a copy of both sides of the patient's medical and prescription insurance card(s) and/or fill out the insurance information below.

Is the patient enrolled in a government-funded healthcare program such as Medicare, Medicaid, VA, DoD, TRICARE, a qualified health plan (QHP), or a plan offered under a state or federal exchange?* ❑ Yes ❑ No

Primary Insurance

Plan name*: _____
ID #*: _____ Group #: _____
Plan phone #*: _____
Policy holder: _____
Date of birth of policy holder (if different from patient): _____/_____/_____
Relationship to patient: _____

Secondary Insurance

Plan name: _____
ID #: _____ Group #: _____
Plan phone #: _____
Policy holder: _____
Date of birth of policy holder (if different from patient): _____/_____/_____
Relationship to patient: _____

Prescription plan provider: _____ Rx ID: _____ Rx Group: _____
Rx BIN: _____ Rx PCN: _____ Rx plan phone #: _____ ❑ Auto-transfer to Specialty Pharmacy if Rx coverage is available

4. Diagnosis and Clinical Information

ICD-10 Code*: ❑ M17.0 ❑ M17.11 ❑ M17.12 ❑ M17.2 ❑ M17.31 ❑ M17.32 ❑ M17.4 ❑ M17.5 ❑ Other: _____
Select the appropriate injection-site location: ❑ Left knee ❑ Right knee ❑ Bilateral
❑ ZILRETTA (date of last injection: _____/_____/_____) (select previous injection-site location): ❑ Left knee ❑ Right knee ❑ Bilateral

Known drug allergies and notes: _____

5. Prescription Information

ZILRETTA® (triamcinolone acetonide extended-release injectable suspension), 32 mg (5 mL) **Quantity:** _____

Directions for use: Administer ZILRETTA as a single intra-articular injection of triamcinolone acetonide, 32 mg (5 mL) for extended release. ZILRETTA is supplied as a single-dose kit containing a vial of 32 mg sterile triamcinolone acetonide (extended-release), 5 mL of sterile diluent, and a sterile vial adapter. Prepare using the diluent supplied in the kit. Refer to the "Instructions for Use" provided with the kit for preparation and administration of ZILRETTA.

Additional directions: _____

Please attach a separate prescription if this section does not comply with your state's prescription law. Prescriptions from New York may be issued electronically.

6. Physician Authorization

By signing below, I certify that (1) the above therapy is medically necessary and in the best interest of the patient listed above; (2) the information provided is complete and accurate to the best of my knowledge; (3) I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Pacira BioSciences and its contractors and business partners ("Contractors") for purposes relating to the FlexForward Program, to solely assist with benefits verification, prior authorization/appeals assistance, and forwarding the above prescription by fax or other means of delivery to a licensed pharmacy to dispense ZILRETTA where appropriate; and (4) I agree to the Business Associate Agreement as presented at https://baa.flexforward.com/.

Healthcare professional name (please print): _____
Healthcare professional signature: _____ Date: _____/_____/_____

For more information, please visit www.zilrettapro.com or call 1-855-793-9727. You are encouraged to report negative side effects of prescription drugs to FDA; visit www.fda.gov/medwatch or call 1-800-FDA-1088.

PACIRA BIOSCIENCES, INC.

FlexForward® Comprehensive Access Support

Zilretta® triamcinolone acetonide extended release injectable suspension 32 mg