ZIMMER BIOMET
Your progress. Our promise.®

APPARIO ENROLLMENT FORM

A Patient Direct Access Program

PATIENT INFORMATION *Indicates Required Field

*Patient Name (Last, First): ______________________ *Date of Birth ______________

*Address: ____

*City: ______________________ *State: __________ *ZIP: __________

*Phone: ______________________ Email: ______________________

PRESCRIBER INFORMATION

*Prescriber Name (Last, First): ______________________ *NPI: ______________________

*Prescriber Phone: ______________________ *Fax: ______________________

*Address: ____

*City: ______________________ *State: __________ *ZIP: __________

PRESCRIPTION INFORMATION

*Patient Name (Last, First): ______________________ *Date: ______________________

☐ **Gel-One® Cross-linked Haluronate (1) 10 mg/ml 3 ml syringe**

Sig: Inject 1 Gel-One syringe into the:

Injection site:	☐ Right Knee	☐ Left Knee	☐ Bilateral
Qty Kits:	☐ 1	☐ 2	

☐ **VISCO-3™ (3) 10 mg/ml 2.5 ml syringes**

Sig: Inject 1 VISCO-3 syringe weekly for three weeks into the:

Injection site:	☐ Right Knee	☐ Left Knee	☐ Bilateral
Qty Kits:	☐ 1	☐ 2	

PRESCRIBER'S SIGNATURE

***Prescriber's Signature:** ______________________ ***Date:** ______________________

PATIENT SIGNATURE

This form must be signed and sent to Truax Patient Services via Fax/email before the medication will be sent.
Truax Patient Services- Appario Program: 1112 Railroad ST SE STE#4/ Bemidji MN 56601/Phone (844)289-3981/Fax (218)444-2267 • Email: appario@tps-rx.com

Authorization to use or disclose Health Information :
This document authorizes the discloser and/or use of individually identifiable health info, set forth below, consistent with federal law concerning the privacy of such information.
Use and Disclosure of Health Information:

I hereby authorize the use of my health information as follows:
Persons/organizations authorized to use or disclose the information: My Insurer, pharmacist, physician, or other health care provider.
Persons/organizations authorized to receive the information: Truax Patient Services and its authorized employees, and Zimmer Biomet and its authorized agents.
Purpose of requested use or disclosure: to (1) confirm my eligibility to receive medications under Appario (the "Program"), (2) facilitate my participation in The Program, (3) administer and audit The Program.
This Authorization applies to the following information: Information about my prescribed medications and medical condition, including prescriptions.
This Authorization may include disclosure of information relating to prescription use only if I sign my name on the appropriate line below. I specifically authorize the release of such information to the person(s) listed above.

Expiration: This Authorization expires on (1) year after I cease to participate in the The Program.

Notice of Rights and Other Information:
I may refuse to sign this Authorization, but such refusal may cause me to be ineligible to participate in The Program.
I may revoke this Authorization at any time by calling (218)444-8217 and mailing a written notice to Truax Patient Services. My Revocation will be effective upon receipt, but will not be to the extent that the requestor or others have acted in reliance upon this Authorization. Revocation of the Authorization would cause me to be ineligible for further participation in The Program.
I understand that once health information about me has been disclosed in reliance upon this Authorization, the information may no longer be protected by Federal Privacy Laws and may be further disclosed.
I have the right to receive a copy of this Authorization.

By signing below, you confirm that , if you have health insurance, you will not submit any claims for reimbursement to your health insurer (private or government) for products you receive through the Appario Program. Signing below also allows Truax Patient Services to send the medication to the Doctors Office.

Name (please print): ______________ **Patient Signature:** ______________ **Date:** __________