



Prior Authorization Form

Synvisc®, Supartz®, Hyalgan®, Euflexxa®, Orthovisc®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Checkboxes for Synvisc®, Supartz®, Hyalgan®, Euflexxa®, Orthovisc®

Checkboxes for New Request, Refill Request (skip question 2 and 3)

Quantity, Refill x months

Instructions

Physician's signature, Provider NPI, MD#

Date, Date medication needed

Patient Information

Patient's name, address, City, State, Zip, phone #, ID#, DOB

Prescriber Information

Prescribing physician, Office address, City, State, Zip, Office contact, Office #, Fax#

Upon approval, delivery is available. Complete section below.

Delivery Requested options: No Delivery Requested, Physician Supply, Member Pick up, Delivery Requested, Physician's office, Patient's home, Preferred Vendor

A copy of the prescription must accompany the medication request

1. DIAGNOSIS FOR DRUG REQUESTED

Osteoarthritis of the knee (Specify ICD9 code), Right, Left, Bilateral, Other (specify)

2. PATIENT'S INFORMATION:

- a. Does the individual have documented symptomatic osteoarthritis of the knee?
b. Does the individual report pain that interferes with functional activities (e.g., ambulation or prolonged standing)?
c. Has the patient tried conservative therapy (including oral medications) without improvement for at least three months?
d. Does the patient have any contraindications to viscosupplementation injections?

3. PATIENT HISTORY

Please list any previous or current therapies related to the diagnosis:

Table with columns: Drug name, Dates, Duration

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (215) 761-9165 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Internal use only section with fields for Document #, M/F, Rx coverage, Previous Auth, Approved, Reviewer Initials, Vendor, LOB, STANDARD - SELECT, Auth#, Date, Billing Code, Processor Initials, Date, From, To, Coverage effective date