AmeriHealth

Prior Authorization Form

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

ONLY COMPLETED REQUESTS WILL BE REVIEWED

☐ **Synvisc®** ☐ **Supartz®** ☐ **Hyalgan®** ☐ **Euflexxa®** ☐ **Orthovisc®** ☐ **Synvisc-One®**

☐ **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_____

Patient's address_____

City, State, Zip: _____

Patient's phone # _____

Patient's ID#:_____ DOB _____

Prescriber Information

Prescribing physician_____

Office address_____

City, State, Zip: _____

Office contact_____

Office #_____ Fax# _____

Upon approval, delivery is available. Complete section below.

☐ **No Delivery Requested**	☐ **Delivery Requested**	
☐ **Physician Supply, authorization only [Flex series]**	☐ **Physician's office**	☐ **Patient's home**
☐ **Member Pick up at pharmacy if benefit available**	**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? ☐ Yes ☐ No

b. Does the individual report pain that interferes with functional activities (e.g., ambulation or prolonged standing)? ☐ Yes ☐ No

c. Has the patient tried conservative therapy (including oral medications) without improvement for at least three months? ☐ Yes ☐ No

d. Does the patient have any contraindications to viscosupplementation injections? ☐ Yes ☐ No

3. PATIENT HISTORY

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

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 Vendor_____ Billing Code_____ **M / Rx**

Document #_____ LOB_____ Processor Initials_____

M F Rx coverage Y N STANDARD - SELECT Date_____

Previous Auth Y N Auth#_____ From_____ To_____

Approved **Reviewer Initials**_____ Date_____Coverage effective date / /