

Today's date _____

Date medication needed _____



Prior Authorization Form Viscosupplementation (Hyaluronate Acid Products)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

PREFERRED BRANDS: Euflexxa® Synvisc® Synvisc-One® Supartz® Hyalgan® Orthovisc®

Check one: New request Refill request (skip questions 2 and 3 below)

Patient information (please print)

Patient name _____

Address _____

City, state, ZIP _____

Patient telephone # _____

Patient ID # _____

Date of birth _____ Height _____ Weight _____

Physician information (please print)

Prescribing physician _____

Office address _____

City, state, ZIP _____

Office contact _____

Office telephone # _____

Fax # _____ NPI _____

Upon approval, delivery is available by completing the section below.

N/A – No delivery requested (authorization only – physician will use office supply)

Delivery requested (indicate where medication should be delivered: Physician's office Patient's home)

****A copy of the prescription must accompany the medication request for delivery.****

1. Diagnosis for drug requested (must include ICD-9):

715.____ Osteoarthritis of the knee: Right Left Bilateral / Date of last injection _____

Other (specify ICD-9) _____

2. Patient medical 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. Is there adequate documentation that the individual does not have functional improvement after a trial period of conservative treatments such as exercise, physical therapy and medication? Yes No

d. For additional courses of treatment: Has the individual experienced significant improvement in pain and functional capacity of the joint(s) since the previous series? Yes No

3. Patient medical information (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:

4. Prescription information:

Quantity _____ Refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's signature _____

Fax completed form to 215-761-9165. Your office will receive a response by fax within two business days.