



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.

<input type="checkbox"/> No Delivery Requested	<input type="checkbox"/> Delivery Requested
<input type="checkbox"/> Physician Supply, authorization only [Flex series]	<input type="checkbox"/> Physician's office <input type="checkbox"/> Patient's home
<input type="checkbox"/> 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. 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

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 / /	