



**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**

<b>Internal use only</b>	Vendor _____	Billing Code _____	<b>M / Rx</b>
Document # _____	LOB _____	Processor Initials _____	
M    F    Rx coverage    Y    N	STANDARD - SELECT	Date _____	
Previous Auth                    Y    N	Auth# _____	From _____ To _____	
<b>Approved    Reviewer Initials</b> _____	Date _____	Coverage effective date    /    /	