



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'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 (888) 671-5285 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL