ACRO Pharmaceutical Services
Tel: (800) 906-7798 Fax: (877) 381-3806
www.acropharmacy.com

HYALURONIC ACID DERIVATIVES

Synvisc®, Synvisc-One™, Supartz®, Euflexxa™, Orthovisc®, Hyalgan®

STATEMENT OF MEDICAL NECESSITY

Please complete this form (PRINT) in its entirety and fax it to the number below.
Be sure to enclose any necessary documentation, labs, insurance cards, etc.

PATIENT DEMOGRAPHICS

Last Name | First Name | Middle Initial | ☐ M ☐ F

Address | Apt# | City | State | ZIP

Home Telephone | Work Telephone | Cell Phone | E-mail

Date of Birth | Social Security Number | Allergies

INSURANCE INFORMATION

Please include copies of the patient's insurance/drug benefit cards (front and back) to expedite benefit clearance.

Primary Insurance Name | Policy Number | Group Number

Policy Holder | Employer | Insurance Telephone Number

PRESCRIBER INFORMATION

Prescriber's Name O | Clinic Name | Contact Name

Prescriber's Name O | Address | City | State | Zip

Prescriber's Name O | Telephone | Fax | Email

Prescriber's Name O | MD NPI # | DEA # | MD License #

CLINICAL INFORMATION

Diagnosis: _____ ICD-9: _____ How was this confirmed: _____

☐ **Synvisc®** ☐ **Synvisc-One™**	To be administered from _____ to _____; or on _____ Date of request:_____ ICD-9: _____ Sig: _____ Total Dose_____
Supartz®	To be administered from _____ to _____; or on _____ Date of request:_____ ICD-9: _____ Sig: _____ Total Dose_____
Euflexxa™	To be administered from _____ to _____; or on _____ Date of request:_____ ICD-9: _____ Sig: _____ Total Dose_____
Orthovisc®	To be administered from _____ to _____; or on _____ Date of request:_____ ICD-9: _____ Sig: _____ Total Dose_____
Hyalgan®	To be administered from _____ to _____; or on _____ Date of request:_____ ICD-9: _____ Sig: _____ Total Dose_____

1. Detailed Non-Pharmacologic & Pharmacologic Therapies History (including names, doses, & dates or a documented medical reason for not using any of these medications): _____
2. List most recent intra-articular injections and the outcomes, or a documented medical reason for not using steroid injections: _____
3. List testing performed to exclude inflammatory arthritis or infection: _____
4. Has the patient received hyaluronic acid derivatives in the past? ☐ No ☐ Yes
   If yes, please list drug & dates of therapy: _____

Physician Signature _____ **Date** _____

Substitution Allowed

Deliver Medication to: ☐ **Patient's Home** ☐ **Physician's Office** ☐ **Other** _____

By signing below, I authorize Acro Pharmaceutical Services ("Acro") to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the "Program"); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to Acro and to the Program. I understand that I may revoke this authorization at anytime by sending a letter to Acro at 313 Henderson Drive, Sharon Hill, PA 19079.

Patient's Signature: _____

Fax completed form to: (877) 381-3806 Thank you for using Acro Pharmaceutical Services!