Capital BlueCross
An Independent Licensee of the Blue Cross and Blue Shield Association

ACRO Pharmaceutical Services

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

HYALURONIC ACID DERIVATIVES

Capital BlueCross Preferred Products: Synvisc-One™, Supartz™

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

Date of Birth | Social Security Number | Allergies

Address | Apt# | City | State | ZIP

Home Telephone | Work Telephone | Cell Phone | Email

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 | MD NPI # | MD License #

Clinic Name | Contact Name

Address | City | State | ZIP

Telephone | Fax | Email

CLINICAL INFORMATION

Diagnosis: _____ **ICD-9**: _____

Capital BlueCross (CBC) Hyaluronic Acid Derivative (HA) Medication Coverage Policy for <u>Non-Medicare Members</u>:

1. CBC will no longer reimburse for hyaluronic acid derivative medications that are bought and billed by a doctor's office for CBC Non-Medicare members. All HA medication requests must be sent to CBC's preferred specialty pharmacy. ACRO will then coordinate the delivery of medication with the prescribing physician's office.

2. CBC has selected **Synvisc-One™** and **Supartz™** to be co-preferred formulary HA medications. Providers will have to submit a letter of medical necessity explaining the medical reason for why either **Synvisc-One™** or **Supartz™** cannot be used to treat a particular patient's condition.

☐ **Synvisc-One™ (48mg/6mL)**	To be administered from _____ to _____; or on _____ Date of request:_____ Sig: _____ Total Dose(s) _____
☐ **Supartz™ (25mg/2.5mL)**	To be administered from _____ to _____; or on _____ Date of request:_____ Sig: _____ Total Doses /Syringes requested: _____

Physician Signature (Required): _____ **Date**_____

Substitution Allowed

Deliver Medication to: ☐ **Physicians 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!

On behalf of Capital BlueCross, ACRO Pharmaceutical Services LLC assists in the administration of physician-administered specialty medications. ACRO Pharmaceutical Services is an independent company.