Sodium Hyaluronate Medical Necessity Form
All areas must be completed

Patient Information:

Name: ______ DOB: ______ ID #: ______

Gender: ☐ M ☐ F Weight: ______ kg / lb (circle one)

Drug Information:

Horizon has designated Euflexxa, Synvisc, and Synvisc-One as the preferred agents in the Hyaluronic Acid category.

Does the physician want to prescribe: ☐ Euflexxa ☐ Synvisc ☐ Synvisc One ☐ Other (please specify agent): ______

Dose: ______ Duration of Therapy: ______

Has the patient received any Sodium Hyaluronate therapy before: ☐ Yes, Therapy: ______ ☐ No

How many injections has the patient received in the past year? ______ Date of Last Dose? ______

What was the outcome of the previous course(s) of therapy? ______

Did patient receive all doses according to appropriate schedules: ☐ Yes ☐ No

Specify the anatomical area of the previous treatment: ☐ Right knee ☐ Left knee ☐ Bilateral knees

Medical and Pharmacy History:

Patient's diagnosis: ______

Joint(s) for treatment: ☐ Right knee ☐ Left knee ☐ Bilateral knees ☐ Other, please specify: ______

Has the patient tried other pharmacological therapeutic options: ☐ Yes ☐ No

Pharmacological:

Drug name & strength:			
Date			
Dose Range:			
Outcome			

Has the patient tried other non-pharmacological therapeutic options: ☐ Yes ☐ No

Non-pharmacological (**please specify the outcomes to all treatments**):

☐ Physical therapy: ______

☐ Supportive devices (cane, brace, etc) : ______

☐ Exercise (type): ______

☐ Ice / Heat: ______

☐ Surgery (please specify: type and date): ______

*****Please attach chart notes documenting outcomes from using the prescribed drug and/or other therapeutic alternatives previously used. *****

Prescriber Information:

Prescriber Name: ______

Nurse or Contact Name: ______

Address: ______

______

Prescriber's Signature: ______

Telephone Number: ______

Fax Number: ______

Presciber's Specialty: ______