



**Prior Authorization Request Form**

**Fax Back To: (800) 853-3844**

**Phone: (800) 711-4555**

**5 AM – 7 PM PST M-F**

**Prescription Solutions Specialty Pharmacy**

**Patient Information**

Patient's name: \_\_\_\_\_

Insurance ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ Sex:  Male  Female

**Provider Information**

Provider's Name: \_\_\_\_\_ Provider ID Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Suite Number: \_\_\_\_\_ Building Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Provider's Specialty: \_\_\_\_\_

Contact at the MD Office: \_\_\_\_\_ Alternate phone: \_\_\_\_\_ Extension: \_\_\_\_\_

**R<sub>x</sub>** ICD9 Code: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Drug: \_\_\_\_\_

Sig: \_\_\_\_\_

Quantity: \_\_\_\_\_ Refill: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

DAW \_\_\_\_\_ (Initial here)

**Delivery Instructions**

Will the physician supply this drug?  Yes  No

Ship to physician's office?  Yes  No

Suite number: \_\_\_\_\_

Bldg number: \_\_\_\_\_

Ship to patient's address?  Yes  No

Ship to other address?  Yes  No

Specify alternate address: \_\_\_\_\_

Date medication needed: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medication Instructions (for Pharmacy)**

Has the patient been instructed on how to Self-administer?  Yes  No

Is this medication a new start?  Yes  No

If **NO** please provide:

Initiation date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last dose: \_\_\_\_/\_\_\_\_/\_\_\_\_

All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

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**Euflexxa- Hyalgan- Orthovisc- Synvisc- Supartz**  
**Osteoarthritis of the knee**

Patients Name: \_\_\_\_\_

Patients ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

**Rx Solutions**  
**Fax # (800) 853-3844**

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**Prescription Solutions Specialty Pharmacy (continued)**

Document the patient's diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Document which knee(s) this request is for:

Right

Left

Bilateral

Other Specify: \_\_\_\_\_

**New Start**

Has the patient previously received an intra-articular corticosteroids injection (ie Solu-Medrol, Prednisolone) of the knee?

Yes  No Date of administration: \_\_\_\_\_

Document if the patient previously received therapy with Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) such as Naprosyn (naproxen), Advil/Motrin (ibuprofen) or Tylenol (acetaminophen):

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Length of therapy: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Length of therapy: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Length of therapy: \_\_\_\_\_

Document if the patient has had a failure, intolerance or contraindication to other hyaluronic acid derivatives:

**Continuation of Therapy**

Document the patient's last injection of this medication: \_\_\_\_\_

Has the patient experienced a decrease in the required doses of Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) such as Naprosyn (naproxen), Advil/Motrin (ibuprofen) or Tylenol (acetaminophen) since the last injection series?  Yes  No

Has the patient had a reduction of pain with previous course of treatment?  Yes  No

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