Prescription Solutions
A UnitedHealth Group Company

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:

℞

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

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

Patients Name: _____ Patients ID#: _____ DOB: _____	Rx Solutions Fax # (800) 853-3844	Page 2 of 2

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: _____

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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