Prior Authorization Form

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

ONLY COMPLETED REQUESTS WILL BE REVIEWED

☐ **Synvisc®** ☐ **Supartz®** ☐ **Hyalgan®** ☐ **Euflexxa®** ☐ **Orthovisc®** ☐ **Synvisc-One™**
☐ **New Request** ☐ **Refill Request (skip question 2 and 3)**
Quantity____________ Refill x____________months
Instructions____
Physician's signature_________________________ Provider NPI: ___________________ MD# _________________________
Date:_____________________ Date medication needed______________________

Patient Information
Patient's name__________________________________
Patient's address___________________________
City, State, Zip: ____
Patient's phone # _________________________
Patient's ID#:___________________ DOB _____________
Upon approval, delivery is available. Complete section below.

Prescriber Information
Prescribing physician_________________________
Office address_______________________________
City, State, Zip: _______________________________________
Office contact_________________________________
Office #______________________ Fax# ____________________

☐ **No Delivery Requested**	☐ **Delivery Requested**
☐ **Physician Supply, authorization only [Flex series]**	☐ **Physician's office** ☐ **Patient's home**
☐ **Member Pick up at pharmacy if benefit available**	**Preferred Vendor:** ______________________________________

****A copy of the prescription must accompany the medication request****

1. DIAGNOSIS FOR DRUG REQUESTED

☐ Osteoarthritis of the knee (Specify ICD9 code) __________________ ☐ **Right** ☐ **Left** ☐ **Bilateral**
☐ Other (specify)______________________________

2. PATIENT'S INFORMATION:

a. Does the individual have documented symptomatic osteoarthritis of the knee? ☐ Yes ☐ No
b. Does the individual report pain that interferes with functional activities (e.g., ambulation or prolonged standing)? ☐ Yes ☐ No
c. Has the patient tried conservative therapy (including oral medications) without improvement for at least three months? ☐ Yes ☐ No
d. Does the patient have any contraindications to viscosupplementation injections? ☐ Yes ☐ No

3. PATIENT HISTORY

Please list any previous or current therapies related to the diagnosis:

Drug name	Dates	Duration
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________

Please add any other supporting medical information that may be useful in the decision-making process:
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FAX TO (215) 761-9165 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Internal use only Vendor____________________ Billing Code______________ **M / Rx**
Document #_________________________ LOB_________________ Processor Initials____________
M F Rx coverage Y N STANDARD - SELECT Date______________________
Previous Auth Y N Auth#______________________ From_______________ To______________
Approved **Reviewer Initials**_______________ Date________________Coverage effective date / /

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield.
Independent licensees of the Blue Cross and Blue Shield Association.