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Blue Shield Injectable Authorization Request Form - *Euflexxa®, Orthovisc®, Supartz®, Hyalgan®, Synvisc®, Synvisc-One®, Gel-One®, Monovisc®*

View our formulary on line at http://www.blueshieldca.com

For a status update while case is under clinical review, please call 1 (800) 541-6652, option 6

Notice: BSC has a 5 Business Day turn-around time on all Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Physician Information	Patient Information
Physician's Name and Address:	Patient's Name:
☐ PCP; ☐ Specialist: _____ PLEASE IDENTIFY SPECIALTY	Blue Shield ID#:
Physician's NPI #	Birthdate:
Office contact:	Date of Request:
Phone#: ( )	WT: HT: BSA:
Facsimile #: ( )	

DRUG NAME: ☐ **Euflexxa** ☐ **Orthovisc** ☐ Other, please list _____

NUMBER OF INJECTIONS: _____

PLACE OF SERVICE FOR ADMINISTRATION:

☐ Physician's office ☐ Home self injection ☐ Home infusion

☐ Infusion Center ☐ Outpatient facility ☐ Other _____

PATIENT CLINICAL INFORMATION

1. Please list diagnosis, ICD-10 code or reason for requesting treatment and attach any clinical information pertinent to this request:

2. If treatment with viscosupplementation is approvable, can patient be treated with Euflexxa or Orthovisc? Yes ☐ No ☐
   - If yes, which viscosupplement will be used and what are the dose and directions?

3. Please check joint to be injected: **Right Knee** ☐ **Left Knee** ☐ **Other** ☐ _____

4. Please attach documentation of diagnosis via recent X-ray or MRI studies, with clinical interpretation included in report.

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Revised: 8/3/2015 Effective: 9/17/2015

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5. Please list **ALL PAST AND PRESENT oral medications received for the requested diagnosis** in the table below.

FAILURE TO PROVIDE INFORMATION (ALL FIELDS) REQUESTED IN THIS TABLE MAY RESULT IN AN INCOMPLETE REQUEST AND AN ADVERSE DETERMINATION DUE TO INSUFFICIENT INFORMATION.

Drug Name	Dates	Dose and Directions	Response
	-		
	-		
	-		
	-		
	-		
	-		

6. Does the patient have documented peptic ulcer disease or gastrointestinal bleeding? Yes ☐ No ☐

- If Yes, please provide documentation of this diagnosis ie: chart notes, diagnostic tests, and labs:

7. Has the patient **previously received any viscosupplement series** to the knee? Yes ☐ No ☐

- If Yes, please provide documentation of previous treatment in the table below.

Name of Viscosupplement	Dates of Therapy	Knee Treated	Response
		Left☐ Right ☐	
		Left☐ Right ☐	
		Left☐ Right ☐	
		Left☐ Right ☐	
		Left☐ Right ☐	

8. Has the patient had a reduction in use of medication following previous use of viscosupplementation? Yes ☐ No ☐

9. Please provide documentation of patient's response to previous viscosupplementation via chart notes.

PLEASE PROVIDE ANY OTHER CLINICAL INFORMATION PERTINENT TO THIS REQUEST

Your signature below indicates the information provided above is true and accurate to the best of your knowledge.

MD SIGNATURE: _____ DATE: _____/_____/_____

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