Clear Form

Synvisc® Orthovisc® Hyalgan® Supartz® Euflexxa® (hyaluronan)

Wellmark BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Treatment Request (Physician to Complete)

Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet Date: ____/____/____

To: Wellmark Pharmacy Services From (Prescriber's Name):_____

Fax Number: (866) 884-4345 Prescriber's DEA Number:_____

Phone Number: (800) 600-8065 Prescriber's Phone Number:_____

Prescriber's Specialty:_____ Prescriber's Fax Number:_____

Prescriber's Office Address:_____

Street Suite # City State Zip

Patient Name:_____

Patient ID:_____ **Patient DOB:** _____/_____/_____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Please provide the diagnosis this therapy has been prescribed for:_____

   _____

   ICD-9 Code:_____

2. Please list all pharmacological therapies tried for this diagnosis and reason(s) for discontinuation:

   _____

   _____

   _____

3. Please list any non-pharmacological therapies tried for this diagnosis: _____

   _____

4. Please select the requested medication
   ❒ Synvisc ❒ Orthovisc ❒ Hyalgan ❒ Supartz ❒ Euflexxa

5. Dose per injection: _____mg Frequency of injection:_____ per _____

6. Please list the dates of previous treatment courses?_____

7. Did the patient experience significant pain relief with prior treatment course?_____

Attach lab results and other documentation as necessary

_____ _____

Printed Name Signature

P-23154 12/08