

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



Treatment Request (Physician to Complete)

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

An Independent Licensee of the Blue Cross and Blue Shield Association

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient, you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy this original fax message.