



**Independence
Blue Cross**

Prior Authorization Form

Synvisc® , 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 _____

Prescriber Information

Prescribing physician _____

Office address _____

City, State, Zip: _____

Office contact _____

Office # _____ Fax# _____

Upon approval, delivery is available. Complete section below.

<input type="checkbox"/> No Delivery Requested	<input type="checkbox"/> Delivery Requested
<input type="checkbox"/> Physician Supply, authorization only [Flex series]	<input type="checkbox"/> Physician's office <input type="checkbox"/> Patient's home
<input type="checkbox"/> 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:

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 / /	