



**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. Is there adequate documentation that the individual does not have functional
 improvement after a trial period of conservative treatments such as exercise, physical
 therapy and medication? 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: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL