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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Hyaluronic Acid Derivatives Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the medication being requested below:</b>					
<input type="checkbox"/> Durolane	<input type="checkbox"/> Gelsyn-3	<input type="checkbox"/> Hymovis	<input type="checkbox"/> Supartz	<input type="checkbox"/> Synvisc-One	
<input type="checkbox"/> Euflexxa	<input type="checkbox"/> Genvisc 850	<input type="checkbox"/> Monovisc	<input type="checkbox"/> Supartz FX	<input type="checkbox"/> TriVisc	
<input type="checkbox"/> Gel-One	<input type="checkbox"/> Hyalgan	<input type="checkbox"/> Orthovisc	<input type="checkbox"/> Synvisc	<input type="checkbox"/> Visco-3	
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Osteoarthritis of the knee					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Medication History:</b>					
Select if the patient has had a trial and failure, contraindication, or intolerance to the following:					
<input type="checkbox"/> Acetaminophen					
<input type="checkbox"/> Formulary non-steroidal anti-inflammatory drugs (NSAIDs)					
<input type="checkbox"/> Tramadol					
<input type="checkbox"/> Intra-articular steroid injection					
<b>For Durolane, Gel-One, Gelsyn-3, Genvisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz or Supartz FX, TriVisc, or Visco-3 requests only:</b>					
Select if the patient has had a trial and failure, contraindication, or intolerance to the following hyaluronic acid derivatives:					
<input type="checkbox"/> Euflexxa					
<input type="checkbox"/> Synvisc					
<input type="checkbox"/> Synvisc-One					
<b>Reauthorization:</b>					
<b>If this is a reauthorization request, answer the following questions:</b>					
Is there documentation the patient has had improvement in pain with the previous course of treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Have at least 6 months elapsed since the last injection of the prior treatment cycle? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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**Please note:** This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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