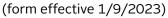
## INTRA-ARTICULAR HYALURONATES PRIOR AUTHORIZATION FORM







Fax to PerformRx<sup>™</sup> at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

PRIOR AUTHORIZATION REQU	EST INFORMATION				
□ New request □ Renewal request	Total # of pages:	Name of c	office contac	t:	
Contact's phone number:		LTC facilit	y contact/pl	none:	
PATIENT INFORMATION					
Patient name:			Patient ID	#:	DOB:
Street address:		Apt.		City/state/zip:	505.
PRESCRIBER INFORMATION Prescriber name:			Specialty		
State license #:	NPI:		Specialty:	MA Provider ID #	
Street address:		Suit	o #•	City/state/zip:	
Phone:		Juit	Fax:	oity/state/zip.	
			FdX.		
CLINICAL INFORMATION					
Agent* requested (*All agents in this class re	, , ,				
<ul> <li>Durolane (preferred)</li> <li>Euflexxa (preferred)</li> </ul>	<ul> <li>Hyalgan (preferred)</li> <li>Hymovis (non-preferred)</li> </ul>			□ Supartz FX (non-preferred) □ Synvisc (non-preferred)	□ Visco-3 (preferred)
Gel-One (non-preferred)	□ Hymovis (non-preferred) □ Monovisc (non-preferred)			Synvisc (non-preferred)	
Gelsyn-3 (preferred)	Orthovisc (non-preferred)			□ Triluron (non-preferred)	
Genvisc 850 (non-preferred)	□ Sodium Hyaluronate (pref	ferred)		□ Trivisc (non-preferred)	
Joint(s) to be injected:  I right knee I lef	t knee 🛛 other** (specify):				
(**For consideration of treatment for other join and other therapies that have been tried.)	nts/indication, submit clinical docun	nentation of	diagnosis, l	medical literature supporting the us	e of the requested agent for the diagnosis,
Medication strength:	Dosage form (syringe, vial, etc.)		Frequenc	y of injection:	Requested duration of therapy:
Diagnosis:					Dx code (required):
PHARMACY INFORMATION (PR	ESCRIBER TO IDENTIFY	THE PH	ARMACY	THAT IS TO DISPENSE	
PHARMACY INFORMATION (PR Deliver to:  Patient's Home Physician'				Y THAT IS TO DISPENSE	
Deliver to:  Patient's Home Physician'					
Deliver to:  Patient's Home Physician' Pharmacy Phone #:	's Office 🛛 Patient's Preferred P	harmacy Na	ıme: Pharmacy		
Deliver to:  Patient's Home Physician' Pharmacy Phone #: I acknowledge that the patient agrees with	's Office 🛛 Patient's Preferred P	harmacy Na	ıme: Pharmacy		
Deliver to:  Patient's Home Physician' Pharmacy Phone #: I acknowledge that the patient agrees with INITIAL REQUESTS	s Office	harmacy Na	nme: Pharmacy cation.	/ Fax #:	THE MEDICATION):
Deliver to:  Patient's Home Physician' Pharmacy Phone #: I acknowledge that the patient agrees with	s Office	harmacy Na of this media ance of any o	me: Pharmacy cation. other pharm	/ Fax #: nacologic and non-pharmacologic th	THE MEDICATION):
Deliver to:  Patient's Home Physician' Pharmacy Phone #: I acknowledge that the patient agrees with INITIAL REQUESTS 1. Does the patient have a history of trial and specific treatment/therapy. Submit docume non-drug treatment (list all):	s Office	harmacy Na of this medi ance of any o ed (or canno	me: Pharmacy cation. other pharm t be tried), c	/ Fax #: nacologic and non-pharmacologic th lates and durations, and outcomes.	THE MEDICATION):
Deliver to:  Patient's Home Physician' Pharmacy Phone #: I acknowledge that the patient agrees with INITIAL REQUESTS Does the patient have a history of trial and specific treatment/therapy. Submit document	s Office	harmacy Na of this medi ance of any o ed (or canno	me: Pharmacy cation. other pharm t be tried), c	/ Fax #: nacologic and non-pharmacologic th lates and durations, and outcomes.	THE MEDICATION):
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Deliver to:       Patient's Home       Physician'         Pharmacy Phone #:       I acknowledge that the patient agrees with         INITIAL REQUESTS         1. Does the patient have a history of trial and specific treatment/therapy. Submit docume         Inon-drug treatment (list all):         medications (specify):         acetaminophe         2. Does the patient have a history of trial and yes – List preferred intra-articular hyalu         No         RENEWAL REQUESTS         1. Did the requested agent improve the patient         2. Record dates all previous intra-articular hyalu	s Office	harmacy Na of this media ance of any of ed (or canno ar corticoste ance of the p ng?	me: Pharmacy cation. other pharm t be tried), c proid injectio preferred int - Submit clii ion of medic	r Fax #: accologic and non-pharmacologic th dates and durations, and outcomes. ns □ other: ra-articular hyaluronates? nical documentation of patient's res cation used and dates of injections. □ date:	THE MEDICATION):         herapies? Check all that apply and record
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