

# UPMC HEALTH PLAN

## Hyaluronic Acid Products: Orthovisc, Euflexxa, Synvisc, Supartz, and Hyalgan Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

**PLEASE TYPE OR PRINT NEATLY**

*Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.*

<b>Office Contact:</b>		<b>Provider Specialty:</b>	
<b>Provider First Name:</b>		<b>Provider Last Name:</b>	
<b>Provider Phone:</b>		<b>Provider Fax:</b>	
<b>Patient Name:</b>	<b>Patient UPMC Health Plan ID Number:</b>	<b>Patient DOB:</b>	<b>Patient Age:</b>
<b>Drug Requested:</b>	<b>Strength:</b>	<b>Frequency:</b>	<b>Qty Dispensed:</b>
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	<b>If ongoing, provide date started:</b>	<b>If medication is ongoing, Did member show improvement while on therapy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diagnosis:</b>		<b>Date of diagnosis:</b>	

### Medical History

<b>Does the member have osteoarthritis of the knee?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Has the member tried and failed a physician directed exercise or physical therapy program?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Has the member tried and failed any of the following conservative treatments for at least 3 months?</b>	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> NSAIDS	<input type="checkbox"/> Other Please list:
<b>Has the member tried and failed an Intra-articular corticosteroid injection?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Does the member have an active joint infection?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Does the member have a bleeding disorder?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No