

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.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:
Patient Name:		Patient UPMC Health Plan ID Number:	Patient DOB:
		Patient Age:	
Drug Requested:	Strength:	Frequency:	Qty Dispensed:
<input type="checkbox"/> Brand <input type="checkbox"/> Generic			
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did member show improvement while on therapy?	<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing medication			<input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	
Please indicate place of administration?		Please indicate how medication will be billed:	
<input type="checkbox"/> Physician Office		<input type="checkbox"/> Billed directly by the provider via JCODE	
<input type="checkbox"/> Hospital/Facility		Provide JCODE: _____	
Please provide facility/provider name and address:		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider	
		<input type="checkbox"/> Billed by a pharmacy and delivered to the patient	

Medical History

Does the member have osteoarthritis of the knee?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate knee being treated:		<input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees
Has the member tried and failed a physician directed exercise or physical therapy program?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the member tried and failed Acetaminophen?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the member tried and failed NSAIDs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the member tried and failed an Intra-articular corticosteroid injection?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member have an active joint infection?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide any additional clinical information which should be considered in the space below:
