UPMC HEALTH PLAN

Hyaluronic Acid Products:
Euflexxa & Synvisc
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: ❑ Brand ❑ Generic	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ New medication ❑ Ongoing medication	**If ongoing, provide date started:**	**If medication is ongoing, Did member show improvement while on therapy?**	❑Yes ❑No
Diagnosis:		**Date of diagnosis:**	
Please indicate place of administration?	❑Physician Office ❑Hospital/Facility	**Please indicate how medication will be billed:** ❑ Billed directly by the provider via JCODE Provide JCODE:_____ ❑ Billed by a pharmacy and delivered to the provider ❑ Billed by a pharmacy and delivered to the patient	
Please provide facility/provider name and address:			

Medical History

Does the member have osteoarthritis of the knee?	❑ Yes ❑ No
Please indicate knee being treated:	❑ Right Knee ❑ Left Knee ❑ Both Knees
Has the member tried and failed a physician directed exercise or physical therapy program?	❑ Yes ❑ No
Has the member tried and failed Acetaminophen?	❑ Yes ❑No
Has the member tried and failed NSAIDs?	❑ Yes ❑ No
Has the member tried and failed an Intra-articular corticosteroid injection?	❑ Yes ❑ No
Does the member have an active joint infection?	❑ Yes ❑ No
Does the member have a bleeding disorder?	❑ Yes ❑ No

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