MedStar Health

MedStar Health
Pharmacy Services
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HYALURONIC ACID PRODUCTS
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

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

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Diagnosis:	Date Diagnosed:

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
Has the member tried and failed the preferred hyaluronic acid product- Euflexxa?	□ Yes □ No

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