Physician Request Form for Physician Administered Hyaluronic Acid Derivates (i.e. Euflexxa® Injection)

Fax to Pharmacy Services at **855-811-9332**, or to speak to a Representative, call **888-602-3741.** *Form must be completed for processing*.

AmeriHealth Caritas District of Columbia

Patient's Name: _____ Patient ID#_____

Address: _____ Apt # or Suite #:_____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Height: _____ Weight: _____lbs = _____Kg Birth Date: _____

Physician's Name: _____ NPI #:__ _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Physician Signature: _____ Date: _____

To be Administered from: _____ to _____ or on:_____ Date of Request::_____

Diagnosis: _____ ICD-9 Diagnosis Code: _____

Select Hyaluronate Product to be Ordered: ☐ Euflexxa ☐ Synvisc ☐ Synvisc-One ☐ Hyalgan ☐ Orthovisc ☐ Supartz

☐ Other_____

Sig (How Administered): _____ Total Dose: _____

● Detailed APAP and NSAID history including names, doses, and dates or a documented medical reason for not using any of these medications:

_____

_____

● List most recent intra-articular injections and the outcomes, or a documented medical reason for not using steroid injections

_____

_____

● If the request is for a Hyaluronic Acid derivative other than Euflexxa, please provide a medical reason for not using Euflexxa to treat the members medical condition:

_____

_____

_____

● Has the patient received hyaluronic acid derivatives (i.e. Synvisc or Hyalgan) in the past? ☐ No ☐ Yes If Yes, list drug and dates of therapy below

_____

_____

Note: Medication will be delivered by a Specialty Pharmacy Provider to either:

☐ The Physician's Office ☐ Other _____

All information requested on this form must be complete. Missing information may result in denial or unnecessary delays in the authorization.

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