

HYALGAN/ORTHOVISC/SUPARTZ/SYNVISC AUTHORIZATION FORM



Attn: Specialty Pharmacy
 PO Box 509075
 San Diego CA 92150-9075
 Phone: 800-711-4555 Option 1 FAX: 800-853-3844
www.RxSol.com

Turn Around Time:
 Routine (48 hours)
 Urgent (24 hours)

Patient Information			Physician Information		
Patient Name:			Primary Care MD:		
Member ID#:			Prescribing MD:		DEA #:
Address:			Specialty:		
City:		State:	Address:		
Zip:	Home Phone:		City:	State:	Zip:
Sex:	DOB:	Age:	Office Phone #:	Office Fax #:	
Height/Weight:		Allergies:	Contact Person:		



<input type="checkbox"/> Hyalgan® 20mg/2ml <input type="checkbox"/> Orthovisc® 30mg/2ml <input type="checkbox"/> Supartz® 25mg/2.5ml <input type="checkbox"/> Synvisc® 16mg/2ml		Strength & Route of Administration:	Frequency:
Date of Initiation:		Diagnosis:	ICD:
Length of Therapy:		Qty:	Refills:
Physician Signature:			Date/Time:

Clinical History & Physical Findings

Osteoarthritis of the knee (Please Specify Which Knee or Bilateral)
 Others (specify)
 Has the patient tried exercise and/or weight reduction? Yes No
 Does the patient use any assistive devices? Yes No
 Has the patient had a trial on intra-articular steroids? Yes No
 If no, are there clinical reasons why such trial would be inappropriate for this patient?

Which medications has the patient tried, along with dates?

Medication	Dosage	Duration of therapy	Reason for Discontinuation	
			Failure	Intolerance
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Delivery Information

Date Needed	<input type="checkbox"/> Patient	<input type="checkbox"/> Physician Office	<input type="checkbox"/> Other (specify)	<input type="checkbox"/> MD Will Supply
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