



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HYALURONIC ACID DERIVATIVES

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:	Physician Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic. Id:
Address:	Address:
City, State, Zip:	City, State, Zip:

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. What is the patient's diagnosis? Clinically documented osteoarthritis Other
Q2. If OTHER, please specify:
Q3. Has the patient tried and failed a course of NSAID therapy, was intolerant to NSAID therapy or are NSAID's contraindicated in this patient? Yes No
Q4. Is the patient intolerant to or are there contraindications to the use of intra-articular corticosteroid injections? Yes No
Q5. Did intra-articular corticosteroid injection show beneficial effects for less than 6 to 8 weeks? Yes No
Q6. Deliver to: Physician's Office Home Delivery
Q7. Delivery date needed:

Physician Signature

Date