PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

HYALURONIC ACID DERIVATIVES

HEALTH PARTNERS
In Wellness and Health, Partners for Life.

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. Has the patient experienced an adequate response to prior treatment cycle as evidenced by documentation of: (check all that apply)

- decreased pain
- decreased pain medication requirements
- documentation of increased function
- none of the above

Q2. Did this prior response last at least 6 months?

Yes No

Q3. Has it been at least 6 months since the last treatment?

Yes No

Q4. Did the patient experience any adverse reactions with prior treatment?

Yes No

Q5. Deliver to:

Physician's Office Home Delivery

Q6. Delivery date needed:

Physician Signature **Date**

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