



Euflexxa[®], Supartz[®], Hyalgan[®] Synvisc[®], Synvisc-One[®] Referral Form

Auth #: _____ Auth Dates: _____ UPMC prior Auth form attached

Patient Information	Date: _____ Patient SS#: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
	Patient's First Name: _____ Patient's Last Name: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Phone #: _____ Alternate Phone #: _____
	DOB: _____ Wt: _____ Caregiver/Emergency Contact: _____ Phone #: _____
	Allergies: _____ Latex: <input type="checkbox"/> Yes <input type="checkbox"/> No

Insurance Information	Primary Insurance: _____ Secondary Insurance: _____
	Insured: _____ Insured: _____
	Phone: _____ Phone: _____
	Policy #: _____ Grp #: _____ Policy #: _____ Grp #: _____

ICD9	Diagnosis: <input type="checkbox"/> 714.0 Rheumatoid Arthritis <input type="checkbox"/> 714.3 Juvenile Rheumatoid Arthritis <input type="checkbox"/> 696.0 Psoriatic Arthritis <input type="checkbox"/> 720.0 Ankylosing Spondylitis <input type="checkbox"/> 715.96 OA-Knee <input type="checkbox"/> 715.____ OA, site: _____ <input type="checkbox"/> Other: _____
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Prescription	Medication	Dose/Strength	Directions	Quantity	Refills
Prescription	<input type="checkbox"/> Euflexxa [®]	20mg/2.0ml NDC: 55566-4100-01	Inject 20mg intra-articularly once weekly	<input type="checkbox"/> 3 syringes <input type="checkbox"/> 6 syringes (bilateral only)	
	<input type="checkbox"/> Supartz [®]	25mg/2.5ml NDC: 08363-7761-01	Inject 25mg intra-articularly once weekly	<input type="checkbox"/> 3 syringes <input type="checkbox"/> 5 syringes <input type="checkbox"/> 6 syringes (bilateral only) <input type="checkbox"/> 10 syringes (bilateral only)	
	<input type="checkbox"/> Hyalgan [®]	20mg/2.0ml NDC: 08024-0724-20	Inject 20mg intra-articularly once weekly	<input type="checkbox"/> 3 syringes <input type="checkbox"/> 5 syringes <input type="checkbox"/> 6 syringes (bilateral only) <input type="checkbox"/> 10 syringes (bilateral only)	
	<input type="checkbox"/> Synvisc [®]	16mg/2.0ml NDC: 58468-0090-01	Inject 16mg intra-articularly once weekly	<input type="checkbox"/> 3 syringes <input type="checkbox"/> 6 syringes (bilateral only)	
	<input type="checkbox"/> Synvisc-One [®]	48mg/10.0ml NDC: 58468-0090-03	Inject 48mg intra-articularly once weekly	<input type="checkbox"/> 1 syringe <input type="checkbox"/> 2 syringes (bilateral only)	

Prescriber Information	Date Shipment Needed: _____ Ship to: _____ Patient _____ Physician/Clinic
	Ship to Other: _____
	Physician's Name (please print): _____
	Office Contact Name: _____
	Phone #: _____ Fax #: _____
	Office Address: _____ City: _____ State: _____ Zip: _____
	Physician's Signature: _____

I authorize Chartwell Pennsylvania Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

PHONE: (800) 755-4704

FAX: (412) 920-1869