reliance|rx℠
45 Earhart Drive, Suite 110, Amherst, NY 14221

INTRA-ARTICULAR INJECTIONS AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:	Today's Date:	Date Needed:	
Date of birth: Sex: Weight:		Prescriber:	Hospital/Clinic:
Home Phone Number: ( )		Phone Number: ( )	Fax Number: ( )
Home Address: City: State: Zip:		Address:	City: State: Zip:
Member's Insurance ID:		Office Phone :	Office Fax Number:
Allergies:		Office Contact:	

STATEMENT OF MEDICAL NECESSITY

ICD10 Code:_____

Primary Diagnosis: _____

-Has patient tried and failed to respond to conservative non-pharmacologic therapy (exercise, physical therapy, weight loss) within the previous 18 months?
☐ Yes ☐ No

-Has patient tried and failed to respond to simple analgesics (oral salicylates, non-steroidal anti-inflammatory drugs [NSAIDs], Acetaminophen) within the previous 18 months?
☐ Yes ☐ No

Hx of medications tried and failed:
_____

When was patient last on these therapies?

-Was patient on Hyaluronate products? ☐ Yes ☐ No

What product(s)?
_____

If yes, when was the last injection?
_____

RETREATMENT MAY BE CONSIDERED, PROVIDED:
-Previous TX cycle was administered at least 6 months ago; and

-Treating physician submits documentation of favorable patient response, including
pain relief derived of more than 3 months in duration; and

-Patient has demonstrated a reduction in analgesic use or increase in functional capacity; and

-Patients progress and results of hyaluronate therapy must be fully documented in the patient's record

DRUG SELECTION

☐ New Authorization ☐ Reauthorization

☐ EUFLEXXA

If request is for a product other than Euflexxa, please check below and document why Euflexxa in not indicated for this patient

☐ GEL-ONE:_____

☐ GELSYN:_____

☐ HYLAGAN:_____

☐ MONOVISC:_____

☐ ORTHOVISC:_____

☐ SUPARTZ:_____

☐ SYNVISC :_____

☐ SYNVISC ONE:_____

Please provide the following information:

Dose Instructions:_____

Frequency:_____

# of syringes needed:_____

SELECT AREA OF INJECTION:

☐ LEFT KNEE ☐ BILATERAL KNEE

☐ RIGHT KNEE ☐ OTHER_____