



Tel: (800) 906-7798 Fax: (877) 381-3806
www.acropharmacy.com

HYALURONIC ACID DERIVATIVES

Synvisc®, Synvisc-One™, Supartz®, Euflexxa™, Orthovisc®, Hyalgan®

STATEMENT OF MEDICAL NECESSITY

Please complete this form (PRINT) in its entirety and fax it to the number below.
Be sure to enclose any necessary documentation, labs, insurance cards, etc.

PATIENT DEMOGRAPHICS

Last Name	First Name	Middle Initial	<input type="checkbox"/> M <input type="checkbox"/> F	
Address	Apt#	City	State	ZIP
Home Telephone	Work Telephone	Cell Phone	E-mail	
Date of Birth	Social Security Number	Allergies		

INSURANCE INFORMATION

Please include copies of the patient's insurance/drug benefit cards (front and back) to expedite benefit clearance.

Primary Insurance Name	Policy Number	Group Number
Policy Holder	Employer	Insurance Telephone Number

PRESCRIBER INFORMATION

Prescriber's Name <input type="checkbox"/>	Clinic Name	Contact Name		
Prescriber's Name <input type="checkbox"/>	Address	City	State	Zip
Prescriber's Name <input type="checkbox"/>	Telephone	Fax	Email	
Prescriber's Name <input type="checkbox"/>	MD NPI #	DEA #	MD License #	

CLINICAL INFORMATION

Diagnosis: _____ ICD-9: _____ How was this confirmed: _____

<input type="checkbox"/> Synvisc®	To be administered from _____ to _____; or on _____	Date of request: _____	ICD-9: _____
<input type="checkbox"/> Synvisc-One™	Sig: _____	Total Dose _____	
Supartz®	To be administered from _____ to _____; or on _____	Date of request: _____	ICD-9: _____
	Sig: _____	Total Dose _____	
Euflexxa™	To be administered from _____ to _____; or on _____	Date of request: _____	ICD-9: _____
	Sig: _____	Total Dose _____	
Orthovisc®	To be administered from _____ to _____; or on _____	Date of request: _____	ICD-9: _____
	Sig: _____	Total Dose _____	
Hyalgan®	To be administered from _____ to _____; or on _____	Date of request: _____	ICD-9: _____
	Sig: _____	Total Dose _____	

- Detailed Non-Pharmacologic & Pharmacologic Therapies History (including names, doses, & dates or a documented medical reason for not using any of these medications): _____
- List most recent intra-articular injections and the outcomes, or a documented medical reason for not using steroid injections: _____
- List testing performed to exclude inflammatory arthritis or infection: _____
- Has the patient received hyaluronic acid derivatives in the past? No Yes
If yes, please list drug & dates of therapy: _____

Physician Signature _____ Date _____

Substitution Allowed

Deliver Medication to: Patient's Home Physician's Office Other _____

By signing below, I authorize Acro Pharmaceutical Services ("Acro") to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the "Program"); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to Acro and to the Program. I understand that I may revoke this authorization at anytime by sending a letter to Acro at 313 Henderson Drive, Sharon Hill, PA 19079.

Patient's Signature: _____

Fax completed form to: (877) 381-3806 Thank you for using Acro Pharmaceutical Services!

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