



Capital BlueCross

An Independent Licensee of the Blue Cross and Blue Shield Association



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

HYALURONIC ACID DERIVATIVES

Capital BlueCross Preferred Products: Synvisc-One™, Supartz™
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

Form with fields for Last Name, First Name, Middle Initial, Date of Birth, Social Security Number, Allergies, Address, Apt#, City, State, ZIP, Home Telephone, Work Telephone, Cell Phone, Email.

INSURANCE INFORMATION

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

Form with fields for Primary Insurance Name, Policy Number, Group Number, Policy Holder, Employer, Insurance Telephone Number.

PRESCRIBER INFORMATION

Form with fields for Prescriber's Name, MD NPI #, MD License #, Clinic Name, Contact Name, Address, City, State, ZIP, Telephone, Fax, Email.

CLINICAL INFORMATION

Diagnosis: ICD-9:

Capital BlueCross (CBC) Hyaluronic Acid Derivative (HA) Medication Coverage Policy for Non-Medicare Members:

- 1. CBC will no longer reimburse for hyaluronic acid derivative medications that are bought and billed by a doctor's office for CBC Non-Medicare members. All HA medication requests must be sent to CBC's preferred specialty pharmacy. ACRO will then coordinate the delivery of medication with the prescribing physician's office.
2. CBC has selected Synvisc-One™ and Supartz™ to be co-preferred formulary HA medications. Providers will have to submit a letter of medical necessity explaining the medical reason for why either Synvisc-One™ or Supartz™ cannot be used to treat a particular patient's condition.

Form with checkboxes for Synvisc-One (48mg/6mL) and Supartz (25mg/2.5mL), and fields for administration details like 'To be administered from' and 'Date of request'.

Physician Signature (Required): Date

Substitution Allowed

Deliver Medication to: Physicians 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!

Important Notice: This communication contains information that is confidential and protected from disclosure. If the reader of this message is not the intended recipient, employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please reply to the sender that you have received the message in error and destroy this copy.

On behalf of Capital BlueCross, ACRO Pharmaceutical Services LLC assists in the administration of physician-administered specialty medications. ACRO Pharmaceutical Services is an independent company.