

# 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

Last Name	First Name	Middle Initial	<input type="checkbox"/> M <input type="checkbox"/> F	
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.**

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

## PRESCRIBER INFORMATION

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:

- 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.
- 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.

<input type="checkbox"/> <b>Synvisc-One™</b> (48mg/6mL)	To be administered from _____ to _____; or on _____ Date of request: _____ Sig: _____ Total Dose(s) _____
<input type="checkbox"/> <b>Supartz™</b> (25mg/2.5mL)	To be administered from _____ to _____; or on _____ Date of request: _____ Sig: _____ Total Doses /Syringes requested: _____

**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!**

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