

Pharmacy Prior Authorization Form

Last Reviewed: Jan. 10

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Hyaluronic acid derivatives, intraarticular (Hyalgan, Synvisc, Supartz, Orthovisc) Urgent Non-urgent

Note: No PA required for Euflexxa (preferred product)

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

The following Hyaluronic acid products are not reimbursable unless the patient had a documented therapeutic trial and inadequate clinical response to Euflexxa, and it has been at least 6 months from the last series of injections.

- Synvisc:** 2 mL injected into the affected knee weekly for 3 weeks (total of 3 injections)
- Synvisc One:** 6 ml injected into the affected knee once
- Orthovisc:** 2 mL injected into the affected knee weekly for 3-4 weeks.
Indicate the duration: 3 weeks 4 weeks
- Hyalgan:** 2 mL injected into the affected knee weekly for 3-5 weeks.
Indicate the duration: 3 weeks 4 weeks 5 weeks
- Supartz:** 2.5 mL injected into the affected knee weekly for 3-5 weeks.
Indicate the duration: 3 weeks 4 weeks 5 weeks

Start date: _____

Place of administration:

- Self-administered
- Provider's Office
- Outpatient Infusion Center Name of center: _____
- Home Infusion Name of agency: _____

Billing options:

- Physician buy and bill (Synvisc J7322, Orthovisc 7324, Hyalgan and Supartz J 7321)
- Preferred Specialty Vendor
- Other: _____

New request or continuation of therapy:

- New
- Continuation of therapy (see continuation section)

Priority Health Precertification Requirements:**Authorization of Hyaluronic Acid Derivatives require:**

- Diagnosis of osteoarthritis of the knee
- Documented therapeutic trial of at least two other pharmacologic therapies

Continuation of Hyaluronic Acid Derivatives require:

- There must be a minimum of six months between injection series

Please Complete the Following Information:

Diagnosis:

- Osteoarthritis of the knee – ICD code: _____
- Other: _____ - ICD code: _____

Please provide rationale for use: _____

Affected Knee:

- Right knee
- Left knee
- Both knees

Patient has tried at least **two** other pharmacologic therapies for osteoarthritis (NSAIDs, COX-2 selective NSAIDs, acetaminophen, IA corticosteroids, tramadol)

- Yes – Please provide names and dates of trials below
- No – Rationale for use: _____

Drug: _____ Trial Dates: _____

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If requesting Synvisc, Orthovisc, Hyalgan or Supartz, has the patient had a documented therapeutic trial and clinical failure with Euflexxa?

- Yes – Please provide date of trial: _____
- No – Rationale for use: _____

Continuation Section:

There has been a minimum of 6 months since the last injection series:

- Yes
- No – Rationale for use: _____

Duration of Authorization:

If all precertification requirements are met approval will be given for one injection series consisting of three to five injections given QW over a period of 3-5 weeks.



Recertification Requirements:

Approve for up to an additional three to five weeks of therapy \geq six months after the last injection from the previous injection series if the patient requires additional therapy.

***** All fields must be complete and legible for Prior Authorization Review*****

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX