

Pharmacy Prior Authorization Form

Last Reviewed: Jan 08

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 (Euflexxa, Hyalgan, Synvisc, Supartz, Orthovisc)

Note: PA not required for Orthopedic Specialists and Physiatrists

Member Name: _____ Member #: _____ - _____
DOB: _____ Sex: _____ Provider Phone: _____
Provider Name: _____ Provider Fax: _____
Provider Office Contact Name: _____ Date: _____

FDA Approved Indication: For the treatment of pain related to knee osteoarthritis for patients who have failed to respond adequately to conservative nonpharmacologic therapy and simple analgesics.

Indicate where the patient will receive injections:

- Ambulatory Infusion Center
Name of Infusion Center: _____
 Physician's office
 Other: _____

Request is for:

- One knee (unilateral)
 Both knees (bilateral)

Indicate the product and dosage requested:

- Euflexxa** (preferred product): 2 mL injected into the affected knee weekly for 3 weeks (total of 3 injections)
- Synvisc**: 2 mL injected into the affected knee weekly for 3 weeks (total of 3 injections)
- 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

Priority Health Precertification Requirements:

1. Indication for requested medication:

- Knee osteoarthritis
 Other: _____

2. Patient has tried at least two other pharmacologic therapies for osteoarthritis (NSAIDs, COX-2 selective NSAIDs, acetaminophen, IA corticosteroids, tramadol) yes no

Drug: _____ Trial Dates: _____

Drug: _____ Trial Dates: _____

Drug: _____ Trial Dates: _____

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Hyalurate

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.

For Internal Use Only

Original Date of Req: _____ Non-Urgent: ___ Urgent: ___ Retro: ___ Method: Phone ___ Fax ___ Ltr ___ Coord. Initial ___
Approved: ___ Denied: ___ Letter Type: Denial ___ 48 hr ___ Off-Label Use ___ Verbal: Y ___ N ___ Inquiry number: _____
Product: HMO ___ PPO ___ ASO ___ POS ___ Caid ___ MICHild ___ Mcare ___ McarePlus ___ McareRX ___ McareValue ___ EGMcare ___
Formulary (11/0030/R0) _____ Non-Formulary (11/0032/R0) _____
Dte Addt Info Req _____ by: Phone ___ Fax ___ Dte 48/OL Ltr sent: _____ Dte 2nd 48/OL Ltr Sent (Caid only) _____
Date All Info Recvd _____ Date of Decision to Deny: _____ RPH Initials: _____
Notified: _____ of Denial on: _____ by: Ph ___ Fax ___