

Pharmacy

PRIOR AUTHORIZATION FORM

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, Synvisc-One, Supartz, Orthovisc)

NOTE: Prior authorization is not required for Euflexxa, the preferred specialty product covered by Priority Health. All other hyalurate products are not reimbursable unless there has been a documented therapeutic trial and inadequate clinical response to Euflexxa, and there is at least 6 months between series of injections.

 URGENT (life threatening)

 Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

 Provider Signature

 Date

PRODUCT INFORMATION

- | | | | | | | | | |
|----------------------------------------------------------|-------------------------------|--------------------------------|-------------------------------------|------|----------------------------|----------------------------|----------------------------|-------|
| <input type="checkbox"/> Hyalgan, given as 2 mL into | <input type="checkbox"/> left | <input type="checkbox"/> right | <input type="checkbox"/> both knees | for | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | weeks |
| <input type="checkbox"/> Orthovisc, given as 2 mL into | <input type="checkbox"/> left | <input type="checkbox"/> right | <input type="checkbox"/> both knees | for | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | | weeks |
| <input type="checkbox"/> Supartz, given as 2.5 mL into | <input type="checkbox"/> left | <input type="checkbox"/> right | <input type="checkbox"/> both knees | for | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | weeks |
| <input type="checkbox"/> Synvisc, given as 2 mL into | <input type="checkbox"/> left | <input type="checkbox"/> right | <input type="checkbox"/> both knees | for | <input type="checkbox"/> 3 | | | weeks |
| <input type="checkbox"/> Synvisc-One, given as 6 mL into | <input type="checkbox"/> left | <input type="checkbox"/> right | <input type="checkbox"/> both knees | once | | | | |

BILLING INFORMATION

Place of administration:

- Provider's Office
- Outpatient Infusion Center
 Center Name: _____
- Home Infusion
 Agency Name: _____

Billing Options:

- Physician buy and bill
- Preferred Specialty Vendor
- Other: _____

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for hyaluronic acid derivatives require the following information to certify:

Patient must have met the following requirements:

- Diagnosis of osteoarthritis of the knee
- Documented therapeutic trial with at least two other pharmacologic therapies
- For continuation of hyaluronic acid, a minimum of six months between injection series

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for hyaluronic acid derivatives requires the following information to certify:

A. What is the patient's diagnosis?

- a. osteoarthritis of the knee ICD code: _____
- b. *Other:* _____
- Rationale for use:* _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

B. Which of the following pharmacologic therapies for osteoarthritis has the patient had a therapeutic trial with (a minimum of two is required)?

- | | | |
|--------------------------------------------------------|-------------|--------------------|
| <input type="checkbox"/> Acetaminophen | Drug: _____ | Trial Dates: _____ |
| <input type="checkbox"/> Cox-2 selective NSAID | Drug: _____ | Trial Dates: _____ |
| <input type="checkbox"/> intraarticular corticosteroid | Drug: _____ | Trial Dates: _____ |
| <input type="checkbox"/> NSAID | Drug: _____ | Trial Dates: _____ |
| <input type="checkbox"/> tramadol | Drug: _____ | Trial Dates: _____ |
- Two of the above have not been tried
- Rationale for use:* _____

C. Has the patient had a therapeutic trial and inadequate response to Euflexxa?

- Yes – Dates Euflexxa was last administered: _____
- No – Rationale for use: _____

D. If the patient has previously received intraarticular hyaluronic acid, has there been a minimum of 6 months since the last injection series?

- Yes – Date of last administration: _____
- No – Rationale for use: _____

OTHER INFORMATION

Note: When authorized, certification will be given for one series of weekly injections, or a single injection for Synvisc-One, to be administered over 3 to 5 weeks, based on the requested product. Recertification is given only when there has been a minimum of 6 months from the previous series for patients requiring 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