Hyaluronates

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital (22)
- ❑ Off Campus Outpatient Hospital (19)
- ❑ Home (12), *skip to Criteria Questions*
- ❑ Office (11), *skip to Criteria Questions*
- ❑ Ambulatory Surgical Center (24), *skip to Criteria Questions*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Clinical Criteria Questions:

1. What drug is being prescribed?

❑ Euflexxa	❑ Gel-One	❑ Gelsyn-3	❑ Hymovis
❑ Hyalgan	❑ GenVisc 850	❑ Monovisc	❑ Orthovisc
❑ Supartz FX	❑ Synvisc	❑ Synvisc One	❑ Triluron
❑ Durolane	❑ sodium hyaluronate	❑ Trivisc	❑ Visco-3
❑ Other _____			

2. What is the diagnosis? ❑ Osteoarthritis of the knee ❑ Other _____
3. What is the ICD-10 code? _____
4. Is the diagnosis supported by radiographic evidence of osteoarthritis of the knee, such as joint space narrowing, subchondral sclerosis, osteophytes, and sub-chondral cysts? *If Yes, skip to #6* ❑ Yes ❑ No

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5. At the time of diagnosis, did/does the patient have ANY of the following signs and symptoms?
   Indicate ALL that apply.
   - ❑ Bony enlargement
   - ❑ Bony tenderness
   - ❑ Crepitus (noisy, grating sound) on active motion
   - ❑ Less than 30 minutes of morning stiffness
   - ❑ No palpable warmth of synovium
   - ❑ Over 50 years of age
   - ❑ Erythrocyte sedimentation rate (ESR) less than 40 mm/hr
   - ❑ Rheumatoid factor less than 1:40 titer (agglutination method)
   - ❑ Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3)
   - ❑ None of the above

6. Does the patient have knee pain which interferes with functional activities (e.g., ambulation, prolonged standing)? ❑ Yes ❑ No

7. Has the patient experienced an inadequate response or adverse effects with non-pharmacologic treatment options (e.g., physical therapy, regular exercise, insoles, knee bracing, weight reduction)? ❑ Yes ❑ No

8. Has the patient experienced an inadequate response or intolerance to a trial of an analgesic (e.g., acetaminophen up to 3 to 4 grams per day, non-steroidal anti-inflammatory drugs [NSAIDs], topical capsaicin cream) for at least 3 months? *If Yes, skip to #10* ❑ Yes ❑ No

9. Does the patient have a contraindication to a trial of an analgesic (e.g., acetaminophen up to 3 to 4 grams per day, non-steroidal anti-inflammatory drugs [NSAIDs], topical capsaicin cream) for at least 3 months? ❑ Yes ❑ No

10. Has the patient experienced an inadequate response or intolerance to a trial of intraarticular steroid injections for at least 3 months? *If Yes, skip to #12* ❑ Yes ❑ No

11. Does the patient have a contraindication to a trial of intraarticular steroid injections for at least 3 months? ❑ Yes ❑ No

12. Is the patient scheduled to undergo a total knee replacement within 6 months of starting treatment? ❑ Yes ❑ No

13. Please indicate if this request is for initiation of therapy (first time use), continuation of therapy (in the middle of a treatment series), or re-start of therapy (the patient has been treated with a viscosupplementation in the past).
   - ❑ Initiation of therapy (first time use) *No further questions*
   - ❑ Continuation of therapy (the patient is in the middle of therapy) No *further questions*
   - ❑ Re-start of therapy (the patient has received a viscosupplementation in the past)

14. Has the patient experienced improvement in pain and functional capacity following the previous injections? ❑ Yes ❑ No

15. Was the previous series of injections completed at least 6 months prior to this request? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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