

## PHARMACY POLICY STATEMENT

### Ohio Medicaid

DRUG NAME	Hyalgan (sodium hyaluronate)
BILLING CODE	J7321
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Gel-One, SupartzFX, Gelsyn-3 QUANTITY LIMIT – 5 injections (5 units)
LIST OF DIAGNOSES CONSIDERED <b>NOT</b> MEDICALLY NECESSARY	<a href="#">Click Here</a>

Hyalgan (sodium hyaluronate) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

### OSTEOARTHRITIS OF THE KNEE

For **initial** authorization:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
  - a) Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI  $\geq 30$ ); AND
  - b) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
  - c) At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
6. Member is not using medication for hip or shoulder related conditions; AND
7. Member is not allergic to avian proteins, feathers, and egg products; AND
8. Member has tried and failed to respond to treatment with Supartz FX or Gel-One or Gelsyn-3 (documented in chart notes and confirmed by claims history).
9. **Dosage allowed:** Inject 20 mg (2 mL) once weekly for up to 5 weeks (total of 5 injections).

***If member meets all the requirements listed above, the medication will be approved for 6 months.***

For **reauthorization**:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

***If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.***

**CareSource considers Hyalgan (sodium hyaluronate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:**

- Refractory interstitial cystitis
- Arthropathy – Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

DATE	ACTION/DESCRIPTION
05/23/2017	New policy for Hyalgan created. Minimum age and BMI requirements changed. Limits of additional courses of treatment changed. Trial of Supartz FX or Gel-One added.
08/04/2017	Trial of Gelsyn-3 added as additional option to the other preferred products.

References:

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14. Hyalgan. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: <http://online.lexi.com>. Accessed May 17, 2017.
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Effective date: 09/01/2017

Revised date: 08/04/2017