Hyaluronic Acid Injections Prior Authorization Form

Non-urgent ☐ Urgent ☐ **Date of administration** _________

Patient Information			
PATIENT NAME:		**DOB:**	
ADDRESS:		**GENDER:** M ☐ F ☐	
PRIMARY INSURANCE:		**SECONDARY INSURANCE:**	
ID #:	**GROUP #:**	**ID #:**	**GROUP #:**

Medication Information

DRUG NAME (Preferred Products): ☐ Supartz FX (J7321) ☐ GelSyn-3 (J7328) ☐ Durolane (J3490)

DRUG NAME (Non-preferred Products): ☐ Synvisc- One (J7325) ☐ Synvisc (J7325) ☐ Euflexxa (J7323) ☐ Hyalgan (J7321) ☐ Monovisc (J7327) ☐ Orthovisc (J7324)

Directions for Use:	**SITE:** ☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other: ______________________________
ADMIN. DATES: _____________TO_____________	**HT:** **WT:** **BMI:**

Statement of Medical Necessity

PRIMARY DIAGNOSIS (ICD-10 CODE)

☐ **YES** ☐ **NO** Is there radiological evidence (x-ray or MRI) to support osteoarthritis? **Attach documentation.**

☐ **YES** ☐ **NO** Has the patient received intra-articular corticosteroid injections?
If so, list date(s):____

☐ **YES** ☐ **NO** Is the patient's BMI >30? If yes, indicate weight loss (_____lbs) or lifestyle modification attempts (examples: diet, exercise, etc):____

☐ **YES** ☐ **NO** Has the patient attempted 2-3 months of bracing/orthotics or physical/occupational therapy?
If yes, indicated attempts and date range:____

☐ **YES** ☐ **NO** If prescribing a non-preferred medication, indicate clinical reason:_______________________
____

Medication History

A. Is member currently treated on this medication?
☐ **YES; How long?** _________________ ☐ **NO**

B. Does the patient have an allergy to avian proteins, feathers or egg products? ☐ **YES** ☐ **NO**

☐ **YES** ☐ **NO** Has the patient been treated with a Hyaluronic Acid Derivative injection in the past?	**Medication**	**Injection site(s)**	**Dates of Therapy**

☐ **YES** ☐ **NO** Has the patient failed at least 3 simple analgesics (i.e. NSAIDs, acetaminophen, oral or topical salicylates)?	**Medication**	**Start Date**	**End Date**

Drug Claim

Claim submitted by:	**TREATING PROVIDER / FACILITY NAME:**		**DRUG CLAIM SUBMITTED TO:**
☐ Physician's Office	**CONTACT:**	**EXTENSION:**	☐ Medical Benefit Only
☐ Outpatient Facility/Hospital	**PHONE:**	**FAX:**	
☐ CVS Caremark Therapeutic Services	**TAX ID:**	**NPI #:**	

Prescribing Physician

PHYSICIAN'S NAME:		**PRESCRIBER'S SPECIALTY:**
ADDRESS:		**TAX ID:**
CITY/STATE/ZIP:		**NPI #:**
OFFICE CONTACT:	**PHONE:**	**FAX:**
PHYSICIAN'S SIGNATURE:		**DATE:**

Fax completed form & clinical documentation to 1-888-399-0271. Questions? Call: 1-800-488-0134.

Please refer to the corresponding medical policy on **www.caresource.com**

Approved Prior Authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits.