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PHARMACY POLICY STATEMENT Kentucky Medicaid	
DRUG NAME	Gelsyn-3 (sodium hyaluronate)
BILLING CODE	J7328
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) Alternative preferred products include Durolane, Supartz FX QUANTITY LIMIT— 3 injection (504 units) - 168 billing units per 2 mL injection
LIST OF DIAGNOSES CONSIDERED NOT MEDICALLY NECESSARY	Click Here

Gelsyn-3 (sodium hyaluronate) is a **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:
 - Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥ 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.
- 7. Dosage allowed: Inject 16.8 mg (2 mL) once weekly for 3 weeks (total of 3 injections).

If member meets all the requirements listed above, the medication will be approved for 6 months. For <u>reauthorization</u>:

- 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.

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CareSource considers Gelsyn-3 (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 Gelsyn-3 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	Product status changed to preferred. Trial of Supartz FX or Gel-One removed.

References:

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- 4. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
- 5. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
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- 13. Leighton R, Åkermark C, Therrien R, et. al. NASHA hyaluronic acid vs methylprednisolone for knee osteoarthritis: a prospective, multi-centre, randomized, non-inferiority trial. Osteoarthritis Cartilage. 2014; 22(1):17-25.

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