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 (J7318) **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 of radiological evidence.** ☐ **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.) below. If lifestyle modifications, list type:_____ ☐ **YES** ☐ **NO** Has the patient attempted 2-3 months of bracing/orthotics or physical/occupational therapy? If yes, indicate attempt type and date range:_____ ☐ **YES** ☐ **NO** Prescribing a non-preferred medication? **Attach documentation to support clinical reason.**	
Medication History	A. Is the patient 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? ☐ **YES** ☐ **NO** Has the patient failed at least 3 simple analgesics (i.e. NSAIDs, acetaminophen, oral or topical salicylates)?	**Medication** / **Injection site(s)** / **Dates of Therapy** **Medication** / **Start Date** / **End Date**
Drug Claim	**Claim submitted by:** ☐ Physician's Office ☐ Outpatient ☐ Facility/Hospital ☐ Accredo Specialty Therapeutic Services	**TREATING PROVIDER / FACILITY NAME:** **CONTACT:** **ADDRESS:** **PHONE/ EXTENSION:** **FAX:** **TAX ID:** **NPI #:**
		DRUG CLAIM SUBMITTED TO: ☐ Medical Benefit Only
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/nc>**

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.