

PHARMACY POLICY STATEMENT

Indiana Medicaid

DRUG NAME	Supartz FX (sodium hyaluronate)
BILLING CODE	J7321
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) Alternative preferred products include Gel-One, Gelsyn-3 QUANTITY LIMIT – 5 injections (5 units)
LIST OF DIAGNOSES CONSIDERED NOT MEDICALLY NECESSARY	Click Here

Supartz FX (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:
 - 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.
8. **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 Supartz FX (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
05/17/2017	New policy for Supartz FX created. Minimum age and BMI requirements changed. Limits of additional courses of treatment changed.

References:

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