

INTRA-ARTICULAR HYALURONATES PRIOR AUTHORIZATION FORM

(form effective 1/5/21)



Fax to PerformRxSM at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request	Total # of pages:	Name of office contact:
Contact's phone number:	LTC facility contact/phone:	

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	
State license #:	NPI:	MA Provider ID #
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

CLINICAL INFORMATION

Agent* requested (*All agents in this class require prior authorization.)

<input type="checkbox"/> Durolane (preferred)	<input type="checkbox"/> Hyalgan (preferred)	<input type="checkbox"/> Supartz FX (non-preferred)	<input type="checkbox"/> Visco-3 (preferred)
<input type="checkbox"/> Euflexxa (preferred)	<input type="checkbox"/> Hymovis (non-preferred)	<input type="checkbox"/> Synvisc (non-preferred)	<input type="checkbox"/> _____
<input type="checkbox"/> Gel-One (non-preferred)	<input type="checkbox"/> Monovisc (non-preferred)	<input type="checkbox"/> Synvisc-One (non-preferred)	
<input type="checkbox"/> Gelsyn-3 (preferred)	<input type="checkbox"/> Orthovisc (non-preferred)	<input type="checkbox"/> Triluron (non-preferred)	
<input type="checkbox"/> Genvisc 850 (non-preferred)	<input type="checkbox"/> Sodium Hyaluronate (preferred)	<input type="checkbox"/> Trivisc (preferred)	

Joint(s) to be injected: right knee left knee other** (specify): _____

(*For consideration of treatment for other joints/indication, submit clinical documentation of diagnosis, medical literature supporting the use of the requested agent for the diagnosis, and other therapies that have been tried.)

Medication strength:	Dosage form (syringe, vial, etc.)	Frequency of injection:	Requested duration of therapy:
Diagnosis:			Dx code (required):

PHARMACY INFORMATION (PRESCRIBER TO IDENTIFY THE PHARMACY THAT IS TO DISPENSE THE MEDICATION):

Deliver to: Patient's Home Physician's Office Patient's Preferred Pharmacy Name:

Pharmacy Phone #: _____ Pharmacy Fax #: _____

I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

INITIAL REQUESTS

1. Does the patient have a history of trial and failure, contraindication, or intolerance of any other pharmacologic and non-pharmacologic therapies? Check all that apply and record specific treatment/therapy. Submit documentation of treatments/therapies tried (or cannot be tried), dates and durations, and outcomes.

non-drug treatment (list all): _____

medications (specify): acetaminophen NSAIDs intra-articular corticosteroid injections other: _____

2. Does the patient have a history of trial and failure, contraindication, or intolerance of the preferred intra-articular hyaluronates?

Yes – List preferred intra-articular hyaluronates tried: _____

No

RENEWAL REQUESTS

1. Did the requested agent improve the patient's condition and level of functioning? Yes - Submit clinical documentation of patient's response to the requested agent. No

2. Record dates all previous intra-articular hyaluronate injections. Submit chart documentation of medication used and dates of injections.

<input type="checkbox"/> right knee	<input type="checkbox"/> date: _____	<input type="checkbox"/> date: _____	<input type="checkbox"/> date: _____	<input type="checkbox"/> date: _____
<input type="checkbox"/> left knee	<input type="checkbox"/> date: _____	<input type="checkbox"/> date: _____	<input type="checkbox"/> date: _____	<input type="checkbox"/> date: _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:
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