Please complete ALL information below and fax your request to 1-888-671-5285

Hyaluronic Acid Derivatives Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the medication being requested below:

❑ Durolane	❑ Gelsyn-3	❑ Hymovis	❑ Supartz	❑ Synvisc-One
❑ Euflexxa	❑ Genvisc 850	❑ Monovisc	❑ Supartz FX	❑ TriVisc
❑ Gel-One	❑ Hyalgan	❑ Orthovisc	❑ Synvisc	❑ Visco-3

Select the diagnosis below:

❑ Osteoarthritis of the knee

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication History:

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:

- ❑ Acetaminophen
- ❑ Formulary non-steroidal anti-inflammatory drugs (NSAIDs)
- ❑ Tramadol
- ❑ Intra-articular steroid injection

For Durolane, Gel-One, Gelsyn-3, Genvisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz or Supartz FX, TriVisc, or Visco-3 requests only:

Select if the patient has had a trial and failure, contraindication, or intolerance to the following hyaluronic acid derivatives:

- ❑ Euflexxa
- ❑ Synvisc
- ❑ Synvisc-One

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had improvement in pain with the previous course of treatment? ❑ **Yes** ❑ **No**

Have at least 6 months elapsed since the last injection of the prior treatment cycle? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.