# INTRA-ARTICULAR HYALURONATES PRIOR AUTHORIZATION FORM

(form effective 1/9/2023)

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative, call **1-888-674-8720**.

## PRIOR AUTHORIZATION REQUEST INFORMATION

| | | |
|---|---|---|
| ☐ New request ☐ 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.)

| | | | |
|---|---|---|---|
| ☐ Durolane (preferred) | ☐ Hyalgan (preferred) | ☐ Supartz FX (non-preferred) | ☐ Visco-3 (preferred) |
| ☐ Euflexxa (preferred) | ☐ Hymovis (non-preferred) | ☐ Synvisc (non-preferred) | ☐ _____ |
| ☐ Gel-One (non-preferred) | ☐ Monovisc (non-preferred) | ☐ Synvisc-One (non-preferred) | |
| ☐ Gelsyn-3 (preferred) | ☐ Orthovisc (non-preferred) | ☐ Triluron (non-preferred) | |
| ☐ Genvisc 850 (non-preferred) | ☐ Sodium Hyaluronate (preferred) | ☐ Trivisc (non-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.*

| | | | | |
|---|---|---|---|---|
| ☐ right knee | ☐ date: _____ | ☐ date: _____ | ☐ date: _____ | ☐ date: _____ |
| ☐ left knee | ☐ date: _____ | ☐ date: _____ | ☐ date: _____ | ☐ date: _____ |

## PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

| | |
|---|---|
| Prescriber signature: | Date: |