Independence

Today's date: _____ **Intended date of injection:** _____

Prior Authorization Form – Viscosupplementation (Hyaluronic Acid Products)

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

PREFERRED BRANDS DO NOT REQUIRE PRIOR AUTHORIZATION: Orthovisc®, Synvisc®, Synvisc-One®

Select one: ☐ Durolane® ☐ Euflexxa® ☐ Gel-One® ☐ Gelsyn-3™ ☐ GenVisc850® ☐ Hyalgan®
☐ Hymovis® ☐ Monovisc® ☐ Supartz® ☐ TriVisc™ ☐ VISCO-3™

Check one: ☐ New start ☐ Continued treatment (skip questions 2a-k)

Patient information (please print)	**Physician information (please print)**	
Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of birth	Fax #	NPI

Authorization is required for Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc850, Hyalgan, Hymovis, Monovisc, Supartz, TriVisc, and VISCO-3.

1) Diagnosis for drug requested (must include ICD-10): _____ ☐ Knee: ☐ Right ☐ Left ☐ Bilateral

2) Patient medical information

a. Does the patient have documented symptomatic osteoarthritis of the knee? ☐ Yes ☐ No
b. Is the patient's knee pain associated with radiographic evidence of osteophytes in the knee joint? ☐ Yes ☐ No
c. Is there sclerosis on a bone adjacent to the knee? ☐ Yes ☐ No
d. Is there joint space narrowing? ☐ Yes ☐ No
e. Does the patient have morning stiffness that lasts less than 30 minutes in duration? ☐ Yes ☐ No
f. Does the patient have knee pain that interferes with functional activities (e.g., walking, prolonged standing)? ☐ Yes ☐ No
g. Can the patient's knee pain be attributed to other forms of joint disease? ☐ Yes ☐ No
h. Is there documentation that the patient does not have functional improvement after at least a 3-month trial of conservative treatment such as exercise, physical therapy, and nonsteroidal anti-inflammatory drugs (NSAIDs)? ☐ Yes ☐ No
i. Has the patient been treated with intra-articular corticosteroid injections?
If no, why? _____ ☐ Yes ☐ No
j. Has the patient had an inadequate response or inability to tolerate two (2) Company-designated preferred viscosupplementation agents (i.e., Orthovisc, Synvisc, Synvisc-One)?
If yes, which agents? _____ ☐ Yes ☐ No
**** Note: This question above applies only to Commercial members.***
k. Does the patient have an avian or egg allergy? ☐ Yes ☐ No

3) For additional courses of treatment

a. Has the patient experienced significant improvement in pain and functional capacity of the joint(s) since the previous series of injections with this agent?
If yes, on which date was the last injection of this agent given? _____ ☐ Yes ☐ No
b. Has the patient experienced significant reduction of other medications (e.g., NSAIDs) or a decreased number of intra-articular corticosteroid injections since the previous series of injections with this agent? ☐ Yes ☐ No

4) Prescription information

Quantity_____ refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's signature _____

Please fax this completed form to 215-761-9580.