Hyaluronic Acid Injections Prior Authorization Form

Non-urgent ☐ Urgent ☐ **Date of administration** _

Patient Information	**PATIENT NAME:**	**DOB:**
	ADDRESS:	**GENDER:** M ☐ F ☐
	PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
	ID #: **GROUP #:**	**ID #:** **GROUP #:**
Medication Information	**DRUG NAME (Preferred Products):** ☐ Supartz FX (J7321) ☐ GelSyn-3 (J7328) ☐ Durolane (J3490) **DRUG NAME (Non-preferred Products):** ☐ Synvisc- One (J7325) ☐ Synvisc (J7325) ☐ Euflexxa (J7323) ☐ Hyalgan (J7321) ☐ Monovisc (J7327) ☐ Orthovisc (J7324)	
	Directions for Use:	**SITE:** ☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other: _____
	ADMIN. DATES: _____ TO _____	**HT:** **WT:** **BMI:**
Statement of Medical Necessity	**PRIMARY DIAGNOSIS (ICD-10 CODE)** ☐ **YES** ☐ **NO** Is there radiological evidence (x-ray or MRI) to support osteoarthritis? **Attach documentation.** ☐ **YES** ☐ **NO** Has the patient received intra-articular corticosteroid injections? If so, list date(s): _____ ☐ **YES** ☐ **NO** Is the patient's BMI >30? If yes, indicate weight loss (_____lbs) or lifestyle modification attempts (examples: diet, exercise, etc): _____ ☐ **YES** ☐ **NO** Has the patient attempted 2-3 months of bracing/orthotics or physical/occupational therapy? If yes, indicated attempts and date range: _____ ☐ **YES** ☐ **NO** If prescribing a non-preferred medication, indicate clinical reason: _____	
Medication History	A. Is member currently treated on this medication? ☐ **YES; How long?** _____ ☐ **NO**	B. Does the patient have an allergy to avian proteins, feathers or egg products? ☐ **YES** ☐ **NO**

☐ **YES** ☐ **NO** Has the patient been treated with a Hyaluronic Acid Derivative injection in the past?

☐ **YES** ☐ **NO** Has the patient failed at least 3 simple analgesics (i.e. NSAIDs, acetaminophen, oral or topical salicylates)?

Medication	**Injection site(s)**	**Dates of Therapy**
Medication	**Start Date**	**End Date**

Drug Claim	**Claim submitted by:** ☐ Physician's Office ☐ Outpatient Facility/Hospital ☐ Accredo Specialty Therapeutic Services	**TREATING PROVIDER / FACILITY NAME:**	**DRUG CLAIM SUBMITTED TO:** ☐ Medical Benefit Only
		CONTACT: **EXTENSION:**	
		PHONE: **FAX:**	
		TAX ID: **NPI #:**	

Prescribing Physician	**PHYSICIAN'S NAME:**	**PRESCRIBER'S SPECIALTY:**	
	ADDRESS:	**TAX ID:**	
	CITY/STATE/ZIP:	**NPI #:**	
	OFFICE CONTACT:	**PHONE:**	**FAX:**
	PHYSICIAN'S SIGNATURE:		**DATE:**

Fax completed form & clinical documentation to 1-888-399-0271. Questions? Call: 1-800-488-0134.

Please refer to the corresponding medical policy on **www.caresource.com**

Approved Prior Authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits.