Hyaluronic Acid Injections Prior Authorization Form

Priority: ☐ Standard ☐ Expedited

Member Information	**Member Name:**	**DOB:**
	Address:	**Member ID:**
	Primary Insurance:	**Secondary Insurance:**
	ID #: **Group #:**	**ID #:** **Group #:**
Medication Information	◯ Supartz/Hyalgan/Viscio-3 (J7321) ◯ GelSyn-3 (J7328) ◯ Durolane (J7318) ◯ Synvisc/Synvisc-One (J7325) ◯ Euflexxa (J7323) ◯ Monovisc (J7327) ◯ Orthovisc (J7324) ◯ Gel-One (J7326) ◯ Other:	
	Directions for Use:	**Injection Site:** ◯ Right Knee ◯ Left Knee ◯ Both Knees ◯ Other: _____
	Admin. Dates: _____ to _____	**HT:** **WT:** **BMI:**
Statements of Medical Necessity	**Primary Diagnosis (ICD-10 Code and Description):**	
	☐ **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 YES, list date(s): _____	
	☐ **YES** ☐**NO** Is the patient's BMI ≥ 30? If YES, indicate weightloss (lbs) or lifestyle modification attempts (examples: diet, exercise, etc.): _____	
	☐ **YES** ☐**NO** Has the patient attempted three months of bracing/orthotics or physical/occupational therapy? If YES, indicated attempts and date range: _____	
	If prescribing a non-preferred medication, indicate clinical reason*: _____	
	***Please attach documentation to support 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?	**Medication** / **Injection site(s)** / **Dates of Therapy**
	☐ **YES** ☐**NO** Has the patient failed at least three simple analgesics (i.e. NSAIDs, acetaminophen, oral or topical salicylates)?	**Medication** / **Start Date** / **End Date**
Servicing Provider Information	**Place of Service:** ☐ Prescriber's Office ☐ Outpatient Facility ☐ Ambulatory Infusion Center ☐ Member's Home	**Servicing Provider Name:**
		Address:
		City/State/Zip: **CareSource ID:**
		Office Contact: **Phone:** **Fax:**
		Tax ID: **NPI #:**
Prescribing Provider Information	**Prescriber Name:**	**Prescriber Speciality:**
	Address:	**Tax ID:**
	City/State/ZIP:	**NPI #:**
	Office Contact: **Phone:**	**Fax:**
	Prescriber Signature:	**Date:**

Fax completed form and clinical documentation to 1-888-399-0271. Questions? Call: 1-800-488-0134.
Please refer to the corresponding pharmacy policy on **www.CareSource.com**. Eligibility of the member at the time of service and timely claim filing limits. Authorizations are not a guarantee of payment and are contingent upon eligibility and benefits.