



**Outpatient Medical Injectable
Intra-Articular Hyaluronan Injections
Request Form: Fax to 833-619-5745 (Medical Benefit Only)**

Member Name: _____

Member Date of Birth: _____

Member UMI: _____ Medicare Commercial

Requesting Physician's Name: _____ NPI Number: _____

Requesting Physician's Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

Facility: _____ Facility NPI Number: _____

Facility's Address: _____

Date of Service: _____

ICD10 Diagnosis Code(s): _____

Supplied by Alliance Rx Walgreens Specialty Pharmacy Buy & Bill Other _____

DRUG INFORMATION (please select one)

**PREFERRED
PRODUCTS**

****These products
DO NOT require
authorization****

- Euflexxa (J7323)
- Supartz (J7321)
- GelSyn-3 (J7328)
- Durolane (J7318)

NON-PREFERRED**

- | | |
|--|--|
| <input type="checkbox"/> Synvisc (J7325) | <input type="checkbox"/> GenVisc 850 (J7320) |
| <input type="checkbox"/> Synvisc-One (J7325) | <input type="checkbox"/> Hymovis (J7322) |
| <input type="checkbox"/> Monovisc (J7327) | <input type="checkbox"/> Synjoynt (J7331) |
| <input type="checkbox"/> Gel One (J7326) | <input type="checkbox"/> Triluron (J7332) |
| <input type="checkbox"/> Hyalgan (J7321) | <input type="checkbox"/> Visco-3 (J7321) |
| <input type="checkbox"/> Orthovisc (J7324) | <input type="checkbox"/> TriVisc (J7329) |

****A non-preferred product may be considered medically necessary if the member has experienced a documented drug therapy failure (after an adequate trial), intolerance, or contraindication to ALL preferred products.**

****Medicare members currently established on a non-preferred therapy are not required to try a preferred option**

****Please specify if the member has tried and failed the following: (Answer below)**

- Euflexxa (J7323) Yes (Date: _____) No
- Supartz (J7321) Yes (Date: _____) No
- GelSyn-3 (J7328) Yes (Date: _____) No
- Durolane (J7318) Yes (Date: _____) No

***Please provide clinical rationale for requesting a non-preferred product for this member:**

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-619-5745

Highmark Blue Shield of Northeastern New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

CLINICAL INFORMATION

Does the member have a diagnosis of symptomatic painful osteoarthritis of the knee with no evidence of inflammatory arthritis? YES NO

Has the member failed to respond adequately to **at least 3 months** of conservative therapy as defined by the following:

- Activity modification, participation in a home exercise program implemented by a physical therapist, protective weight bearing. YES NO
- Non-narcotic analgesics (e.g., acetaminophen, NSAIDS) at Food and Drug Administration (FDA) or compendia based recommended therapeutic doses for osteoarthritis of the knee for a period of time adequate to assess therapeutic benefit, topical external analgesic preparations including capsaicin cream applied to affected knee joint, topical anti-inflammatory preparations applied to affected knee joint.
 YES NO
- Intra-articular corticosteroid injections. YES NO

Is the member unable to tolerate conservative therapy due to adverse side effects **or** other medical conditions?
 YES NO

Can cause of pain be attributed to other forms of joint disease other than osteoarthritis? YES NO

Will the injections be performed by a licensed medical professional (e.g., MD, DO, PA or CRNP)? YES NO

Does the member have any contraindications to hyaluronan injections? YES explain: _____ NO

New Start

Request for Repeat Treatment

Date of last series: _____

Has the member and provider elected to continue conservative/non-surgical management of the osteoarthritis (no surgery planned within six (6) months of viscosupplementation therapy)

YES NO

Is there a documented reduction in the dose of analgesics or anti-inflammatory medications in the three (3) month period following the injection series (NOTE: not required if the member requires these medications for a comorbid medical condition in addition to knee osteoarthritis)

YES NO

Is there a documented significant improvement in pain and functional capacity of the knee joint. (ex: an improvement in an objective measurement of pain and/or functional status VAS, WOMAC Index, or other validated objective measure)

YES NO

Please attach all pertinent clinical information

Attached: YES NO

****Please verify member's eligibility and benefits through the health plan****

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