Pennsylvania
Department of Human Services

Medical Assistance BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
July 1, 2026	July 6, 2026	*See below

SUBJECT

Prior Authorization of Intra-Articular Hyaluronates – Pharmacy Services

BY

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IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: https://www.pa.gov/agencies/dhs/resources/for-providers/provider-enrollment-information/provider-enrollment-documents

PURPOSE:

The purpose of this bulletin is to issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Intra-Articular Hyaluronates submitted for prior authorization.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program. The guidelines to determine the medical necessity of Intra-Articular Hyaluronates will be utilized in the fee-for-service and managed care delivery systems. Providers rendering services to MA beneficiaries in the managed care delivery system should address any questions related to the prior authorization of Intra-Articular Hyaluronates to the appropriate managed care organization.

BACKGROUND:

The Department of Human Services' (Department) Drug Utilization Review (DUR) Board meets to review provider prescribing and dispensing practices for efficacy, safety, and

*01-26-64	09-26-64	27-26-50	33-26-53
02-26-50	11-26-49	30-26-49	
03-26-50	14-26-53	31-26-65	
08-26-64	24-26-63	32-26-49	

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Fee-for-Service Provider Service Center: 1-800-537-8862

Visit the Office of Medical Assistance Programs website at:
https://www.pa.gov/agencies/dhs/departments-offices/omap-info

quality and to recommend interventions for prescribers and pharmacists through the Department's Prospective DUR and Retrospective DUR programs.

DISCUSSION:

During the May 12, 2026, meeting, the DUR Board recommended a revision to the guidelines for renewal of a prior authorization request for an Intra-Articular Hyaluronate to clarify that the beneficiary experienced improvement of their condition following the most recent treatment with an Intra-Articular Hyaluronate rather than the first treatment with an Intra-Articular Hyaluronate.

The revisions to the guidelines to determine medical necessity of prescriptions for Intra-Articular Hyaluronates submitted for prior authorization, as recommended by the DUR Board, were subject to public review and comment and subsequently approved for implementation by the Department.

PROCEDURE:

The procedures for prescribers to request prior authorization of Intra-Articular Hyaluronates are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Intra-Articular Hyaluronates) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs and products that require prior authorization.

ATTACHMENTS:

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

RESOURCES:

Prior Authorization of Pharmaceutical Services Handbook – SECTION I
Pharmacy Prior Authorization General Requirements
https://www.pa.gov/agencies/dhs/resources/pharmacy-services/pharmacy-prior-authorization-general-requirements

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines
https://www.pa.gov/agencies/dhs/resources/pharmacy-services/clinical-guidelines

I. Requirements for Prior Authorization of Intra-Articular Hyaluronates

A. Prescriptions That Require Prior Authorization

All prescriptions for Intra-Articular Hyaluronates must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Intra-Articular Hyaluronate, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Intra-Articular Hyaluronate for the treatment of a diagnosis that is consistent with the U.S. Food and Drug Administration-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

2. Has a documented history of therapeutic failure of or a contraindication or an intolerance to **all** of the following:

   a. Non-pharmacologic treatments,
   b. Acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs),
   c. Intra-articular glucocorticoid injection;

   AND

3. Does not have a contraindication to the requested agent; **AND**

4. For a non-preferred Intra-Articular Hyaluronate, has a history of therapeutic failure of or a contraindication or an intolerance of the preferred Intra-Articular Hyaluronates. See the Preferred Drug List (PDL) for the list of preferred Intra-Articular Hyaluronates at: https://papdl.com/preferred-drug-list; **AND**

5. If a prescription for an Intra-Articular Hyaluronate is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: https://www.pa.gov/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR INTRA-ARTICULAR HYALURONATES: The determination of medical necessity of a request for renewal of a prior authorization for an Intra-Articular Hyaluronate that was previously approved will take into account whether the beneficiary:

1. Has documented improvement in pain or joint function following the most recent treatment; **AND**

2. Did not receive an Intra-Articular Hyaluronate in the same joint within the past six months; **AND**

3. Does not have a contraindication to the requested agent; **AND**

4. For a non-preferred Intra-Articular Hyaluronate, has a history of therapeutic failure of or a contraindication or an intolerance of the preferred Intra-Articular Hyaluronates. See the PDL for the list of preferred Intra-Articular Hyaluronates at: https://papdl.com/preferred-drug-list; **AND**

5. If a prescription for an Intra-Articular Hyaluronate is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: https://www.pa.gov/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

B. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Intra-Articular Hyaluronate. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

C. Dose and Duration of Therapy

Requests for prior authorization of an Intra-Articular Hyaluronate will be approved for one treatment course per knee.

D. References

1. Kolasinski SL, et.al. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Management of Osteoarthritis of the Hand, Hip, and Knee. Arthritis Care Res (Hoboken). 2020 Feb;72(2):149-162.
2. Recommendations for the Use of Nonpharmacologic and Pharmacologic Therapies in Osteoarthritis of the Hand, Hip, and Knee. Arthritis Care & Research. 64(4), April 2012, 465–474.
3. Fernandes, L. et.al, EULAR recommendations for the non-pharmacological core management of hip and knee osteoarthritis. Ann Rheum Dis doi:10.1136/annrheumdis-2012-202745. Published Online First 17 April 2013.
4. Jordan, K.M. et.al, EULAR Recommendations 2003: an evidence based approach to the management of knee osteoarthritis: Report of a Task Force of the Standing Committee for International Clinical Studies Including Therapeutic Trials (ESCISIT) Ann Rheum Dis, Publish Online First: 21 July 2003; 62: 1145 - 1155.
5. McAlindon, T.E. et.al, OARSI guidelines for the non-surgical management of knee osteoarthritis. Osteoarthritis and Cartilage 22 (2014) 363e388.
6. American Academy of Orthopaedic Surgeons Management of Osteoarthritis of the Hip Evidence-Based Clinical Practice Guideline. aaos.org/oahcpg2 Published 12/01/2023.
7. American Academy of Orthopaedic Surgeons Management of Osteoarthritis of the Knee (Non-Arthroplasty) Evidence-Based Clinical Practice Guideline. https://www.aaos.org/oak3cpg Published 08/31/2021.
8. Deveza, L.A. et.al. Management of knee osteoarthritis. UpToDate accessed 4/2/2026.
9. Deveza, L.A. et.al. Overview of the management of osteoarthritis UpToDate accessed 4/2/2026.