

**Hyaluronan PreDetermination of Medical Benefits**  
**[ Euflexxa™, Hyalgan®, Orthovisc®, Supartz®, Synvisc® ]**  
 Complete form in its entirety and fax to UM Call Center at (404) 848-2448

<b>Click on grey boxes to type</b>	<b>Request Date:</b>	/ /
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<input type="checkbox"/> Initial Authorization Request	<input type="checkbox"/> Re-Authorization Request; List Prior Auth Ref #:
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<input type="checkbox"/> Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800.870.6419)
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1. PATIENT INFORMATION			
Patient Last Name	Patient First Name	Anthem Member ID Number	Patient DOB / /
Contact Phone Number ( ) -	Primary Diagnosis	ICD-9 Code(s)	Patient's Weight (lbs) Date:

2. PHYSICIAN INFORMATION			
Physician Last Name	Physician First Name	Physician DEA or NPI Number	Physician Tax ID
Address		City	State Zip Code
Office Phone Number ( ) -	Office Fax Number ( ) -	Office Contact Name	Physician Specialty

3. MEDICATION INFORMATION – This section serves as the active prescription signature required.			
Drug Name <input type="checkbox"/> Euflexxa <input type="checkbox"/> Hyalgan <input type="checkbox"/> Supartz <input type="checkbox"/> Orthovisc <input type="checkbox"/> Synvisc	HCPCS or CPT Code(s) <input type="checkbox"/> J7323 <input type="checkbox"/> J7321 <input type="checkbox"/> J7324 <input type="checkbox"/> J7322	Strength / Dose	
Direction for Use (SIG)			
Date patient is scheduled to be treated (need by date) / /	Service From Date / /	Service Thru Date / /	Number of Refills
Ship Medication to: <input type="checkbox"/> MD Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other: (please specify)			

4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: <b>To avoid delays</b> , please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended. If indicated, please provide <b>ALL</b> supporting lab results, progress notes, etc.

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**(1) Osteoarthritis of the Knee (initial course/cycle)**  
 Yes  No Does patient have pain due to osteoarthritis of the knee?

**(2) Osteoarthritis of the Knee (repeat treatment)**  
 Yes  No Has it been 6 months or more since the initial prior treatment cycle?  
 Yes  No Did the patient have a positive response to the initial course/cycle as confirmed by adequate pain relief, or an increase in or maintenance of function?

**(3) Reducing and Non-reducing Disc Displacement of the Temporomandibular Joint**  
 Yes  No Does the patient have pain due to reducing and non-reducing disc displacement disease of the temporomandibular joint?

**(4) Other Use(s)** (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(5)**  Yes  No Does the patient have any allergies to avian proteins, feathers and/or egg products?

**5. PHYSICIAN SIGNATURE**

<u>Prescriber's or Authorized Representative's Signature:</u> _____	<u>Date:</u> ____ / ____ / ____
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Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

**IMPORTANT WARNING:** This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is **STRICTLY PROHIBITED**. If you have received this message by error, please notify us immediately at 800-722-6614 and destroy the related message or return the document to us at 3350 Peachtree Rd. NE, Atlanta, GA 30326. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.

**Medical Policy Reference can be found at:** [www.bcbsga.com](http://www.bcbsga.com)  
Anthem UM Services, Inc. an independent company and is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.