CONTAINS CONFIDENTIAL PATIENT INFORMATION

Anthem UM Services, Inc.

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

Click on grey boxes to type	Request Date: / /

☐ Initial Authorization Request	☐ Re-Authorization Request; List Prior Auth Ref #:

☐ Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800.870.6419)

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	HCPCS or CPT Code(s)	Strength / Dose
☐ Euflexxa	☐ J7323	
☐ Hyalgan ☐ Supartz	☐ J7321	
☐ Orthovisc	☐ J7324	
☐ Synvisc	☐ J7322	

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: ☐ MD Office ☐ Patient's Home
☐ Other: (please specify)

4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: **To avoid delays**, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended.
If indicated, please provide **ALL** 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 ☐ Does the patient have any allergies to avian proteins, feathers and/or egg products?

5. PHYSICIAN SIGNATURE

Prescriber's or Authorized Representative's Signature:	**Date:** ____/____/_____
_____	

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.

Medical Policy Reference can be found at: 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.