Health Net of the Northeast

VISCOSUPPLEMENTATION PRIOR AUTHORIZATION Request Fax Form

For Status Of A Request Call: 1-800-867-6564

FAX TO: 1-800-977-8226

FORM MUST BE FULLY COMPLETED TO AVOID A PROCESSING DELAY. PLEASE PRINT.

Patient's Name (Last, First, MI)	Member ID #	Date of Birth
Patient's Street Address / City / State / Zip Code		Allergies
Patient Plan Type (State Mandated Appeal Requirement-This information is required.) ☐ Commercial ☐ Medicaid ☐ Medicare		
Physician's Name (Last, First, MI)	Phone Number ( )	Fax Number ( )
Physician's Address / City / State / Zip Code	License #	DEA / NPI #

I. Requested Medication

☐ Euflexxa- one dose per week (3 total doses)
☐ Hyalgan- one dose per week (3 to 5 total doses) Doses requested: _________
☐ Synvisc- one dose per week (3 total doses)
☐ Orthovisc- one dose per week (3 to 4 total doses) Doses requested: _________
☐ Supartz- one dose per week (5 total doses)

Ia. Indicate which knee is being treated: ☐ **Right** ☐ **Left** ☐ **Both**

II. Diagnosis of osteoarthritis confirmed by the following (check all that apply):

Synvisc and Hyalgan are FDA indicated for the treatment of pain in osteoarthritis (OA) of the knee in patients who have failed to respond adequately to conservative nonpharmacologic therapy and simple analgesics, e.g., acetaminophen

☐ Laboratory results (i.e. ESR): Test name: ______________________ Result (date): ______________
☐ Radiograph results – *please attach a copy of the results*
☐ Severity and duration of symptoms: ______________________
☐ Functional limitations: ______________________
☐ Progress notes documenting the above attached.

III. Physical Therapy

☐ NO. Please explain: ______________________
☐ YES. Please indicate dates of physical therapy: ______________ to ______________

IV. Pharmacological Therapy

A. Previous Therapy Medications (Include dose)	Dates of use

B. Current Therapy Medications (Include dose)	Dates of use

C. Corticosteroid intra-articular injections (Required)

☐ NO. Please explain: ______________________
☐ YES. Please indicate dates of injection(s): ______________________

Physician's Signature:

Note: Health Net Pharmaceutical Services (HNPS) reviews only the authorization for medical necessity of the medication. Provision of the medication by a vendor and/or nursing care associated with the administration of the medication must also be Prior Authorized by Health Net.

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. In New York, said civil penalties shall not exceed five thousand dollars and the stated value of the claim for each violation.

Mailing Address: HNPS Prior Authorization Department 10540 White Rock Road #280 Rancho Cordova CA 95670