Humana Clinical Pharmacy Review
1-877-486-2621 (Fax)
www.humana.com

HUMANA PHARMACY Solutions℠

Euflexxa® (sodium hyaluronate), Hyalgan® (sodium hyaluronate), Orthovisc® (high molecular weight hyaluronan), Supartz® (sodium hyaluronate), Synvisc® (hylan G-F 20), Synvisc-One® (hylan G-F 20)

Please note any information left blank or illegible may delay the review process

Member Information

Name: | Date of birth:

Subscriber ID#: | Home Phone:

☐ Female ☐ Male | Address:

City: | State: | ZIP code:

Where is the medication being administered?

☐ Prescriber's office ☐ Home Health ☐ Outpatient Facility

Facilities other than prescriber's office, please provide the following: Name:

Tax ID#:

Physician Information

Name: | Tax ID#:

Address:

City: | State: | ZIP code:

Telephone: | Fax:

Physician specialty/facility name (if

Physician signature (required): | Date:

Diagnosis and Medical Information

Is the medication being requested for use in an ongoing clinical trial? ☐ Yes ☐ No

If yes, is the drug requested the study drug? ☐ Yes ☐ No

Is this a reauthorization? ☐ Yes ☐ No

If yes, please provide month and year of last treatment

Does the member have documented improvement on therapy? ☐ Yes ☐ No

ICD-9 Code: | **J Code:**

Has there been inadequate response to any of the following after at least three months?

☐ NSAIDs ☐ acetaminophen ☐ intra-articular corticosteroids

☐ Narcotics ☐ salicylates

Does the member have documented symptomatic osteoarthritis of the knee and therapy is limited to the knee? ☐ Yes ☐ No

Has there been inadequate response to conservative nonpharmacologic treatments? ☐ Yes ☐ No

If yes, please check all which apply:

☐ Education

☐ Assisted devices

☐ Strengthening and range of motion exercises

☐ Weight loss

Other (please specify the diagnosis):

For medical necessity reviews, you must provide a unique peer-reviewed journal article to support your request for off-labeled use.
Please attach any medical information that may support approval.

Medication and Dose Requested

☐ Euflexxa (sodium hyaluronate) ☐ Hyalgan (sodium hyaluronate) ☐ Orthovisc (high molecular weight hyaluronan)

☐ Supartz (sodium hyaluronate) ☐ Synvisc (hylan G-F 20) ☐ Synvisc-One (hylan G-F 20)

Dosage: | Sig:

Medications are subject to a quantity limitation sufficient for a 30-day supply per fill based on FDA-approved dosages.

Prior Authorization of Benefits 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.