

Hyaluronan Prior Authorization

[Euflexxa™, Hyalgan®, Orthovisc®, Supartz®, Synvisc®]

Complete form in its entirety and fax to Anthem UM Services (303) 831 6428 or (800) 763-3142

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) Yes No

1. PATIENT INFORMATION			
Patient Last Name	Patient First Name	Patient ID Number	Patient DOB / /
Address	City	State / Zip Code /	Contact Phone Number () -
Date of Diagnosis / /	Primary Diagnosis	ICD-9 Code(s)	Patient's Current Weight

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
Place of Service <input type="checkbox"/> MD Office <input type="checkbox"/> Pt's Home <input type="checkbox"/> Other: (please specify)			
Prescriber Signature			Date / /

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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.

(1) Osteoarthritis of the Knee (initial course/cycle)

- Yes No Does pt have pain due to osteoarthritis of the knee?
- Yes No Has pt failed to respond adequately to conservative non-pharmacologic therapy (e.g., activity modification, home exercises, protective weight bearing) and to simple analgesics (e.g., acetaminophen)?

(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 pt 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 pt have pain due to reducing and non-reducing disc displacement disease of the temporomandibular joint?
- Yes No Has pt failed to respond adequately to conservative non-pharmacologic therapy (e.g., activity modification, home exercises, protective weight bearing) and to simple analgesics (e.g., acetaminophen)?

(4) Other Use(s) (This will not be reviewed unless all supporting evidence/documentation, labs, etc., are attached.)

5. PHYSICIAN SIGNATURE

	/ /
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Prescriber 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.

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