Anthem UM Services, Inc.

CONTAINS CONFIDENTIAL PATIENT INFORMATION

# 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 | 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 |
|---|---|---|---|
| / / | / / | / / | |

Place of Service

☐ MD Office ☐ Pt's Home ☐ 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

| | |
|---|---|
| | / / |
| **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.