Viscosupplementation Injectable Medication Precertification Request

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: ☐ Start of treatment ☐ Continuation of therapy: ☐ Right knee ☐ Left knee ☐ both knees **Today's date:** _____
Date of last treatment: _____ **Date needed:** _____

Ship to: ☐ Doctor's office ☐ Patient ☐ Other: _____ Phone: _____

Dispensing Provider: ☐ Aetna Specialty Pharmacy® or ☐ Other: _____
Phone: _____ Fax: _____ **TIN:** _____ PIN: _____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If Yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If Yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If Yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Circle one):* M.D. D.O. N.P. P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ Orthopedic ☐ **Primary Provider** ☐ **Other**: _____

D. DIAGNOSIS INFORMATION - Please indicate primary ICD-9 code and specify any other any other where applicable (*).

Primary ICD-9: ☐ _____ ☐ Other ICD-9 Code: _____

E. CLINICAL INFORMATION - All clinical questions must be completed for precertification request.

Requesting prior authorization for viscosupplementation therapy for: ☐ **Right knee** ☐ **Left knee** ☐ **both knees**

Please indicate which drug you are requesting: ***(P** is preferred, **NP** is non-preferred)*

☐ **Euflexxa® (P)** ☐ **Hyalgan® (NP)** ☐ **Orthovisc® (P)** ☐ **Supartz® (NP)** ☐ **Synvisc® (NP)** ☐ **Synvisc One® (NP)**

☐ Yes ☐ No Does the patient have documented symptomatic osteoarthritis of the knee?
☐ Yes ☐ No Has the patient had a documented failure after at least 3 months of conservative therapy (including physical therapy, pharmacotherapy, i.e. non steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, and/or topical capsaicin cream)?
☐ Yes ☐ No Is the patient unable to tolerate conservative therapy because of adverse side effects?
☐ Yes ☐ No Has the patient failed to adequately respond to aspiration and injection of intra-articular steroids?
☐ Yes ☐ No Does the patient report pain which interferes with functional activities (i.e., ambulation, prolonged standing)?
If Yes, is the pain attributed to other forms of joint disease? ☐ Yes ☐ No
☐ Yes ☐ No Does the patient have any contraindications to the injections (i.e., active joint infection, bleeding disorder)?
☐ Yes ☐ No Has the patient had a documented trial and failure of Euflexxa and Orthovisc?
If Yes, please provide the dates of treatment for both products:
Euflexxa: _____ Orthovisc: _____

If requesting additional series of injections for patient: Date of last injection from prior series: _____

☐ Yes ☐ No Did the patient respond adequately to the prior series of injections?
☐ Yes ☐ No Does the patient's medical record demonstrate a reduction in the dose of NSAIDs (or other analgesics or anti-inflammatory medication) during the period following the previous series of injections?
☐ Yes ☐ No Does the patient's medical record document significant improvement in pain and functional capacity as the result of the previous injections?

F. PRESCRIPTION – To be completed for precertification request. Prescriptions will be forwarded to Aetna Specialty Pharmacy unless otherwise noted.

MEDICATION - Refer to CPB # 0179	ASRx DISPENSING?	DIRECTIONS	QUANTITY
☐ **Euflexxa** (sodium hyaluronate 1%)	☐ Yes ☐ No		
☐ **Hyalgan** (sodium hyaluronate)	☐ Yes ☐ No		
☐ **Orthovisc** (high molecular weight form of hyaluronic acid)	☐ Yes ☐ No		
☐ **Supartz** (sodium hyaluronate)	☐ Yes ☐ No		
☐ **Synvisc** (hylan G-F 20)	☐ Yes ☐ No		
☐ **Synvisc One** (hylan G-F 20)	☐ Yes ☐ No		

***If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.**
***If the prescriber is providing the drug, the provider must verify benefits.**

Prescriber's Signature: _____ **Date:** ____/____/____
(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)

Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY" in this space: _____