REVIEW REQUEST FOR

Hyaluronan Injections in the Knee

Anthem UM Services, Inc.

Provider Data Collection Tool Based on Clinical Guideline DRUG-29

Policy Last Review Date: 11/03/2016	Policy Effective Date: 12/28/2016	Provider Tool Effective Date: 12/28/2016

Request Date: / / ☐ **Initial Authorization Request** ☐ **Subsequent Authorization Request** ☐ Buy and bill		
Individual's Name:		Date of Birth: / /
Insurance Identification Number:		Individual's Phone Number:
Primary Diagnosis:	Diagnosis Code(s) (if known):	Individual's Weight ___________ ☐(lbs) ☐(kg)
Ordering Provider Name & Specialty:		Provider ID Number:
Office Address:		
Contact Name and Office Phone Number:		Office Fax Number:
Servicing Provider Name & Specialty (**If different than Ordering Provider**):		Provider ID Number:
Office Address:		
Contact Name and Office Phone Number:		Office Fax Number:
Place of Service: ☐ Home ☐ Office ☐ Dialysis Center ☐ Outpatient Hospital ☐ Ambulatory Infusion ☐ Ambulatory Infusion Center ☐ Other: ___________		
Drug Name/HCPCS Code (if known) Euflexxa ☐ J7323 Orthovisc ☐ J7324 Gel-One ☐ J7326 Supartz ☐ J7321 Gel-Syn ☐ J7328 Synvisc ☐ J7325 Gel-Visc 850 ☐ Q9980 (code deleted 12/31/16) GenVisc 850 ☐ J7320 (code effective 01/01/17) Synvisc-One ☐ J7325 Hyalgan ☐ J7321 Hymovis ☐ J7321 ☐ J7322 (code effective 01/01/17) Monovisc ☐ J7327 Other: ___________	Dose to be administered: ___________ (mg) ___________ (Other)	
When did the individual first start this drug? / /	Frequency For This Request (Days, Wks, Months) ___________	
Duration For This Request: ___________ (Weeks)	Start Date For This Request: / /	

This clinical guideline based data collection tool is for a medical necessity review request for **initial and repeat hyaluronan injections** for the replacement or supplementation of naturally occurring intra-articular lubricants in individuals with osteoarthritis in the knees (also known as viscosupplementation).

Please check all of the following that apply to the individual.

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1. Initial Request for hyaluronan treatment of the knee

- ☐ **The request is for** an initial course of intra-articular injections of hyaluronan
  - ☐ Individual has pain due to osteoarthritis of the knee
  - ☐ A diagnosis of osteoarthritis of the knee has been documented
  - ☐ There is no evidence of inflammatory arthritis (for example, rheumatoid arthritis)
  - ☐ There is documentation that the pain interferes with functional activities (for example, ambulation, prolonged standing)
  - ☐ There is documentation of failure to respond adequately to at least 3 months of conservative therapy. (IF checked, mark all of the following that apply to the individual)
    - ☐ Activity modification,
    - ☐ Home exercise,
    - ☐ Protective weight bearing
    - ☐ Analgesics (for example, acetaminophen or non-steroidal anti-inflammatory drugs [NSAIDs])
    - ☐ The individual is unable to tolerate conservative therapy because of adverse side effects
    - ☐ Other ______________
  - ☐ There are no contraindications to the injections (for example, active joint infection, bleeding disorder).

2. Repeat Course of intra-articular injections of hyaluronan treatment of the knee

- ☐ The individual has met all of the criteria for an initial course of treatment **(listed above)**
- ☐ Six (6) months, or more, have elapsed since the conclusion of the prior treatment cycle
- ☐ Provide the completiion date of the most recent intra-articular injection of hyaluronan treatment of the knee: ______________
- ☐ There is documentation that the individual has experience pain relief and improvement in functional status from the prior course of hyaluronan treatment
- ☐ Other ______________

2. Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

☐ Pre-Claim

☐ Post–Claim. If checked, please attach the claim or indicate the claim number ________________

I confirm that the information entered on this form is accurate and complete based on the records available at the time of this request. I understand the health plan or its designees may request medical documentation to verify the accuracy of the information reported on this form.

____________________________________ / /

Name & Title of Provider or Provider Representative Completing Form & attestation (Please Print)* Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.