HIGHMARK
NORTHEASTERN NEW YORK

Outpatient Medical Injectable
Intra-Articular Hyaluronan Injections
Request Form: Fax to 833-619-5745 (Medical Benefit Only)

Member Name: _____

Member Date of Birth: _____

Member UMI: _____ ☐ Medicare ☐ Commercial

Requesting Physician's Name: _____ NPI Number: _____

Requesting Physician's Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

Facility: _____ Facility NPI Number: _____

Facility's Address: _____

Date of Service: _____

ICD10 Diagnosis Code(s): _____

☐ **Supplied by Alliance Rx Walgreens Specialty Pharmacy** ☐ **Buy & Bill** ☐ **Other** _____

DRUG INFORMATION (*please select one*)

PREFERRED PRODUCTS

These products DO NOT require authorization

- ☐ **Euflexxa (J7323)**
- ☐ **Supartz (J7321)**
- ☐ **GelSyn-3 (J7328)**
- ☐ **Durolane (J7318)**

NON-PREFERRED**

- ☐ Synvisc (J7325)
- ☐ Synvisc-One (J7325)
- ☐ Monovisc (J7327)
- ☐ Gel One (J7326)
- ☐ Hyalgan (J7321)
- ☐ Orthovisc (J7324)
- ☐ GenVisc 850 (J7320)
- ☐ Hymovis (J7322)
- ☐ Synojoynt (J7331)
- ☐ Triluron (J7332)
- ☐ Visco-3 (J7321)
- ☐ TriVisc (J7329)

****A non-preferred product *may be considered medically necessary* if the member has experienced a documented drug therapy failure (after an adequate trial), intolerance, or contraindication to ALL preferred products.**

****Medicare members currently established on a non-preferred therapy are not required to try a preferred option**

****Please specify if the member has tried and failed the following:** *(Answer below)*

Euflexxa (J7323) ☐ **Yes (Date: _____)** ☐ **No**
Supartz (J7321) ☐ **Yes (Date: _____)** ☐ **No**
GelSyn-3 (J7328) ☐ **Yes (Date: _____)** ☐ **No**
Durolane (J7318) ☐ **Yes (Date: _____)** ☐ **No**

***Please provide clinical rationale for requesting a non-preferred product for this member**: _____

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-619-5745

CLINICAL INFORMATION
Does the member have a diagnosis of symptomatic painful osteoarthritis of the knee with no evidence of inflammatory arthritis? ☐ YES ☐ NO
Has the member failed to respond adequately to **at least 3 months** of conservative therapy as defined by the following: • Activity modification, participation in a home exercise program implemented by a physical therapist, protective weight bearing. ☐ YES ☐ NO • Non-narcotic analgesics (e.g., acetaminophen, NSAIDS) at Food and Drug Administration (FDA) or compendia based recommended therapeutic doses for osteoarthritis of the knee for a period of time adequate to assess therapeutic benefit, topical external analgesic preparations including capsaicin cream applied to affected knee joint, topical anti-inflammatory preparations applied to affected knee joint. ☐ YES ☐ NO • Intra-articular corticosteroid injections. ☐ YES ☐ NO
Is the member unable to tolerate conservative therapy due to adverse side effects **or** other medical conditions? ☐ YES ☐ NO
Can cause of pain be attributed to other forms of joint disease other than osteoarthritis? ☐ YES ☐ NO
Will the injections be performed by a licensed medical professional (e.g., MD, DO, PA or CRNP)? ☐ YES ☐ NO
Does the member have any contraindications to hyaluronan injections? ☐ YES explain: _____☐ NO

☐ **New Start**	☐ **Request for Repeat Treatment** Date of last series: _____ Has the member and provider elected to continue conservative/non-surgical management of the osteoarthritis (no surgery planned within six (6) months of viscosupplementation therapy) ☐ YES ☐ NO Is there a documented reduction in the dose of analgesics or anti-inflammatory medications in the three (3) month period following the injection series (NOTE: not required if the member requires these medications for a comorbid medical condition in addition to knee osteoarthritis) ☐ YES ☐ NO Is there a documented significant improvement in pain and functional capacity of the knee joint. (ex: an improvement in an objective measurement of pain and/or functional status VAS, WOMAC Index, or other validated objective measure) ☐ YES ☐ NO

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**

****Please verify member's eligibility and benefits through the health plan****

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