HEALTH PLANS
UNIVERSITY OF UTAH

MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM

HYALURONIC ACID

Amvisc®, Euflexxa®,Gelsn-3®, Genvisc®, Healon®, Hyalgan®, Orthovisc®, Provisc®, Synvisc®, Synvisc-One®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Amvisc® (1.6% sodium hyaluronate), ☐ Euflexxa® (1% sodium-hyaluronate), ☐ Gelsn3® (hyaluronic acid), ☐ Genvisc® (sodium hyaluronate), ☐ Healon® (sodium hyaluronate), ☐ Hyalgan® (sodium hyaluronate), ☐ Orthovisc® (sodium hyaluronate), ☐ Provisc® (sodium hyaluronate), ☐ Synvisc® (hylan G-F 20) , ☐ Synvisc-One® (hylan G-F 20)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request for treatment of Osteoarthritis of the tibiofemoral articulation of the knee?	☐	☐	
2. Is the member between the ages of 40-65?	☐	☐	
3. Does the member have a BMI ≤ 40?	☐	☐	
4. Is the requesting provider made by, or in consultation with, a sports medicine physician, physical medicine and rehabilitation physician, rheumatologist, orthopedist, or a pain management specialist?	☐	☐	
5. Does the member have a diagnosis of grade II or III primary osteoarthritis of the knee?	☐	☐	**Please provide documentation**
6. Is the member experiencing moderate to severe functional impairment evidence by at least 1 of the following: • Functional impairment with poor mobility • Increased pain with prolonged standing • Frequent flares requiring use of analgesics or NSAIDs, corticosteroids, etc.	☐	☐	**Please provide documentation**

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7. Has the member had a trial and failure of a physician directed exercise or physical therapy program?	☐	☐	**Please provide documentation**
8. Has the member had a trial and failure of acetaminophen and/or topical capsaicin, and prescription strength non-steroidal anti-inflammatory drugs (NSAIDs) for ≥3 months?	☐	☐	**Please provide documentation**
9. Has the member had a trial and failure of intra-articular steroid injection (triamcinolone) within the past 6 months?	☐	☐	**Please provide documentation**
10. Has the member had a tried an orthotic device (e.g. knee brace) without benefit?	☐	☐	**Please provide documentation**
11. Does the physician anticipate a total knee replacement within the next 6 months?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show decreased pain and improved functional capacity since first treatment cycle?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- M001
Origination Date: 01/10/2019
Reviewed/Revised Date: 08/19/2020
Next Review Date: 08/19/2021
Current Effective Date: 09/01/2020

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