



Today's date: _____

Intended date of injection: _____

Prior Authorization Form – Viscosupplementation (Hyaluronic Acid Products)

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

PREFERRED BRANDS DO NOT REQUIRE PRIOR AUTHORIZATION: Monovisc®, Orthovisc®, Synvisc®, Synvisc-One®

Select one: Durolane® Euflexxa® Gel-One® Gelsyn-3™ GenVisc850® Hyalgan®
 Hymovis® Supartz® Synjoynt™ Triluron™ TriVisc™ VISCO-3™

Check one: New start Continued treatment (skip questions 2a-k): Please fax progress notes of prior injections.

Patient information (please print)

Physician information (please print)

Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of birth	Fax #	NPI

Authorization is required for Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc850, Hyalgan, Hymovis, Supartz, Synjoynt, Triluron, TriVisc, and VISCO-3.

1) Diagnosis for drug requested (must include ICD-10): _____ Knee: Right Left Bilateral

2) Patient medical information

- a. Does the patient have documented symptomatic osteoarthritis of the knee? Yes No
- b. Is the patient's knee pain associated with radiographic evidence of osteophytes in the knee joint? Yes No
- c. Is there sclerosis on a bone adjacent to the knee? Yes No
- d. Is there joint space narrowing? Yes No
- e. Does the patient have morning stiffness that lasts less than 30 minutes in duration? Yes No
- f. Does the patient have knee pain that interferes with functional activities (e.g., walking, prolonged standing)? Yes No
- g. Can the patient's knee pain be attributed to other forms of joint disease? Yes No
- h. Is there documentation that the patient does not have functional improvement after at least a 3-month trial of conservative treatment such as exercise, physical therapy, and nonsteroidal anti-inflammatory drugs (NSAIDs)? Yes No
- i. Has the patient been treated with intra-articular corticosteroid injections?
If no, why? _____ Yes No
- j. Has the patient had a documented contraindication, or documented non-response, to all preferred products (Monovisc, Orthovisc, and a Synvisc product [either Synvisc or Synvisc-One])? Yes No
- k. Does the patient have an avian or egg allergy? Yes No

3) For additional courses of treatment

- a. Has the patient experienced significant improvement in pain and functional capacity of the joint(s) since the previous series of injections with this agent?
If yes, on which date was the last injection of this agent given? _____ Yes No
- b. Has the patient experienced significant reduction of other medications (e.g., NSAIDs) or a decreased number of intra-articular corticosteroid injections since the previous series of injections with this agent? Yes No

4) Prescription information

Quantity _____ refill x _____ month(s)
 Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)
 Physician's signature _____

Please fax this completed form to 215-761-9580.