AmeriHealth

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: Orthovisc®, Synvisc®, Synvisc-One®

Select one: ☐ Euflexxa® ☐ Gel-One® ☐ GelSyn™ ☐ GenVisc850® ☐ Hyalgan® ☐ Hymovis® ☐ Monovisc® ☐ Supartz® ☐ VISCO-3™

Check one: ☐ New start ☐ Continued treatment (skip questions 2a-k)

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 required for Euflexxa, Gel-One, GelSyn, GenVisc850, Hyalgan, Hymovis, Monovisc, Supartz, and VISCO-3.**

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

2) Patient medical information

a. Does the individual 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 report 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? ☐ Yes ☐ No
If no, why? _____

j. Has the patient had an inadequate response or inability to tolerate two (2) Company-designated preferred viscosupplementation agents (i.e., Orthovisc, Synvisc, Synvisc-One)? Which agents?_____ ☐ Yes ☐ No
**** Note: This question applies only to Commercial members.***

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? ☐ Yes ☐ No
If yes, on which date was the last injection of this agent given? _____

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.