HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
ZILRETTA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

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: ☐ Zilretta® (triamcinolone acetonide extended release injectable suspension)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Does the member have a BMI ≤40?	☐	☐	
3. Is the prescription written by or in consultation with a sports medicine physician, physical medicine and rehabilitation physician, rheumatologist, orthopedist, or pain management specialist?	☐	☐	
4. Does the member have a diagnosis of grade II or grade III primary osteoarthritis of the knee?	☐	☐	**Please provide documentation**
5. Does the member have a diagnosis of grade IV osteoarthritis of the knee and is contraindicated for a total knee replacement?	☐	☐	**Please provide documentation**
6. Is the member experiencing moderate to severe functional impairment with at least one 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**
7. Has the member had a trial and failure of ALL of the following: • Physician directed exercise or a physical therapy program	☐	☐	**Please provide documentation**

• Simple analgesics such as acetaminophen and/or topical capsaicin AND prescription strength NSAIDs for at least 3 months • Orthotic device like a knee brace • History of a positive but inadequate response to at least one other intra-articular glucocorticoid injection of the knee			
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 Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HU-M010
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 06/01/2025