HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
HYALURONIC ACID

Euflexxa®, Gel-One®, Gelsyn-3®, Genvisc®, Hyalgan®, Orthovisc®, Supartz®, Synvisc®, Synvisc-One®, Vicso-3™

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 888-509-8142.

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

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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: ☐ Euflexxa® (1% sodium-hyaluronate), ☐ Gel-One® (cross-linked hyaluronate), ☐ Gelsyn-3® (hyaluronic acid), ☐ Genvisc® (sodium hyaluronate), ☐ Hyalgan® (sodium hyaluronate), ☐ Orthovisc® (sodium hyaluronate), ☐ Supartz® (sodium hyaluronate), ☐ Synvisc® (hylan G-F 20) , ☐ Synvisc-One® (hylan G-F 20), ☐ Visco-3™ (sodium hyaluronate)

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 knee?	☐	☐	
2. Does the member have a body mass index (BMI) ≤ 40 kg/m2?	☐	☐	**Please provide documentation**
3. Is the request made by, or in consultation with, a sports medicine physician, physical medicine and rehabilitation physician, rheumatologist, orthopedist, or a pain management specialist?	☐	☐	
4. Does the member have a diagnosis of grade II or III primary osteoarthritis of the knee confirmed with imaging?	☐	☐	**Please provide documentation**
5. 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, NSAIDs, or corticosteroids?	☐	☐	**Please provide documentation**
6. Has the member had a trial and failure of physician directed exercise or physical therapy?	☐	☐	**Please provide documentation**

7. 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**
8. Has the member had a trial and failure of an intra-articular steroid injection (triamcinolone) within the past 6 months?	☐	☐	**Please provide documentation**
9. Has the member tried an orthotic device such as a knee brace?	☐	☐	**Please provide documentation**
10. 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:			

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Policy PHARM- M001
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