

HYALURONIC ACID PRODUCTS Prior Authorization Form

<input type="checkbox"/> Standard Request <input type="checkbox"/> Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For state exchanges only: The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.
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Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	<input type="checkbox"/> Generic <input type="checkbox"/> Brand Necessary
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>		
<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

<input type="checkbox"/> Billed by PHARMACY dispensed to the member or provider for administration.	<input type="checkbox"/> Billed under MEDICAL benefit by provider. J CODE: _____ ICD-10 Code: _____	Place of Administration: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient Home
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Clinical Information

Diagnosis:	Date Diagnosed:
Does the member have osteoarthritis of the knee? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please indicate knee being treated: <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Both Knees	
Has the member tried and failed a physician directed exercise or physical therapy program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the member tried and failed Acetaminophen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the member tried and failed NSAIDs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the member tried and failed an Intra-articular corticosteroid injection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member have an active joint infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member have a bleeding disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the member tried and failed the preferred hyaluronic acid product- Euflexxa? <input type="checkbox"/> Yes <input type="checkbox"/> No	