

INTRA-ARTICULAR HYALURONIC ACID AGENTS PRIOR AUTHORIZATION FORM

- To review the prior authorization guidelines for IA Hyaluronic Acid Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Intra-Articular Hyaluronic Acid Agents and Quantity Limits/Daily Dose Limits** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	PA#: _____				
Name of office contact: _____			Specialty: _____		
Contact's phone number: _____			State license #: _____		
LTC facility contact/phone: _____			NPI: _____	MA Provider ID#: _____	
RECIPIENT INFORMATION			Street address: _____		
Recipient Name: _____			Suite #: _____	City/state/zip: _____	
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

CLINICAL INFORMATION

Agent* requested (*All agents in this class require prior authorization.)			
<input type="checkbox"/> Euflexxa	<input type="checkbox"/> Hyalgan	<input type="checkbox"/> Orthovisc	<input type="checkbox"/> Synvisc
<input type="checkbox"/> Gel-One	<input type="checkbox"/> Hymovis	<input type="checkbox"/> Supartz	<input type="checkbox"/> Synvisc-One
<input type="checkbox"/> Genvisc 850	<input type="checkbox"/> Monovisc	<input type="checkbox"/> Supartz FX	<input type="checkbox"/> _____
Joint(s) to be injected: <input type="checkbox"/> right knee <input type="checkbox"/> left knee <input type="checkbox"/> other** (specify): _____ <small>(**For consideration of treatment for other joints/indication, submit clinical documentation of diagnosis, medical literature supporting the use of the requested agent for the diagnosis, and other therapies that have been tried.)</small>			
Medication strength: _____	Frequency of injection: _____	Requested duration of therapy: _____	
Diagnosis: _____		Dx code (required): _____	
Specialty Pharmacy Drug Program: Intra-Articular Hyaluronic Acid Agents are part of the Department's Specialty Pharmacy Drug Program (SPDP). Which specialty pharmacy will be used?		<input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreens Specialty Pharmacy	

Section A: Initial requests

1. What other treatments or therapies has the Recipient tried? <i>Check all that apply and record specific treatment/therapy.</i> <input type="checkbox"/> non-drug treatment (list all): _____ <input type="checkbox"/> medications (specify): <input type="checkbox"/> acetaminophen <input type="checkbox"/> NSAIDs <input type="checkbox"/> other: _____ <input type="checkbox"/> intra-articular corticosteroid injections (specify agent(s) and joint(s) treated): _____	<i>Submit documentation of treatments/therapies, dates and durations, and outcomes of therapies</i>
2. Does the Recipient have any contraindications or intolerances to the preferred agents listed in question (1)? <input type="checkbox"/> Yes – <i>submit all supporting documentation of contraindications and intolerances</i> <input type="checkbox"/> No	

Section B: Renewal requests

1. Did the requested agent improve the Recipient's condition and level of functioning? <input type="checkbox"/> Yes – <i>submit clinical documentation of Recipient's response to the requested agent</i> <input type="checkbox"/> No	
2. Record dates all previous <u>intra-articular hyaluronic acid injections</u> . <input type="checkbox"/> right knee date: _____ date: _____ date: _____ date: _____ <input type="checkbox"/> left knee date: _____ date: _____ date: _____ date: _____	<i>Submit chart documentation of medication used and dates of injections.</i>

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
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