INTRA-ARTICULAR HYALURONATES PRIOR AUTHORIZATION FORM

(form effective 1/9/2023)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:			Patient ID #:	DOB:
Street address:		Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION

Prescriber name:		Specialty:	
State license #:	NPI:	MA Provider ID #	
Street address:	Suite #:	City/state/zip:	
Phone:	Fax:		

CLINICAL INFORMATION

Agent* requested (*All agents in this class require prior authorization.)

☐ Durolane (preferred)	☐ Hyalgan (preferred)	☐ Supartz FX (non-preferred)	☐ Visco-3 (preferred)
☐ Euflexxa (preferred)	☐ Hymovis (non-preferred)	☐ Synvisc (non-preferred)	☐ _____
☐ Gel-One (non-preferred)	☐ Monovisc (non-preferred)	☐ Synvisc-One (non-preferred)	
☐ Gelsyn-3 (preferred)	☐ Orthovisc (non-preferred)	☐ Triluron (non-preferred)	
☐ Genvisc 850 (non-preferred)	☐ Sodium Hyaluronate (preferred)	☐ Trivisc (non-preferred)	

Joint(s) to be injected: ☐ right knee ☐ left knee ☐ other** (specify):_____

*(**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.)*

Medication strength:	Dosage form (syringe, vial, etc.)	Frequency of injection:	Requested duration of therapy:
Diagnosis:			Dx code (required):

PHARMACY INFORMATION (PRESCRIBER TO IDENTIFY THE PHARMACY THAT IS TO DISPENSE THE MEDICATION):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #: Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

INITIAL REQUESTS

1. Does the patient have a history of trial and failure, contraindication, or intolerance of any other pharmacologic and non-pharmacologic therapies? Check all that apply and record specific treatment/therapy. Submit documentation of treatments/therapies tried (or cannot be tried), dates and durations, and outcomes.
   ☐ non-drug treatment (list all): _____
   _____
   ☐ medications (specify): ☐ acetaminophen ☐ NSAIDs ☐ intra-articular corticosteroid injections ☐ other: _____
   _____

2. Does the patient have a history of trial and failure, contraindication, or intolerance of the preferred intra-articular hyaluronates?
   ☐ Yes – *List preferred intra-articular hyaluronates tried*: _____
   ☐ No

RENEWAL REQUESTS

1. Did the requested agent improve the patient's condition and level of functioning? ☐ Yes - *Submit clinical documentation of patient's response to the requested agent.* ☐ No

2. Record dates all previous intra-articular hyaluronate injections. *Submit chart documentation of medication used and dates of injections.*

☐ right knee	☐ date: _____	☐ date: _____	☐ date: _____	☐ date: _____
☐ left knee	☐ date: _____	☐ date: _____	☐ date: _____	☐ date: _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: