INTRA-ARTICULAR HYALURONATES PRIOR AUTHORIZATION FORM





(form effective 1/9/2023)

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

	EST INFORMATION				
☐ New request ☐ Renewal request	wal request Total # of pages: Name of o			act:	
Contact's phone number:	LTC facility contact/phone:				
PATIENT INFORMATION					
Patient name:			Patient I	D #:	DOB:
Street address:		Apt.	#:	City/state/zip:	
PRESCRIBER INFORMATION					
Prescriber name:			Specialt	<i>t</i> :	
State license #:	NPI:		- p	MA Provider ID #	
Street address:		Suit	e #:	City/state/zip:	
Phone:			Fax:		
CLINICAL INFORMATION			1		
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 (pref	Terrea)		☐ Trivisc (non-preferred)	
Joint(s) to be injected: ☐ right knee ☐ left					
(**For consideration of treatment for other join and other therapies that have been tried.)	ts/indication, submit clinical docum	mentation of	diagnosis	medical literature supporting the use	e of the requested agent for the diagnosis,
Medication strength:	Dosage form (syringe, vial, etc.)		Frequen	cy 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 #:		,	Pharma	v Fav #·	
□ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.					
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<u> </u>	the pharmacy chosen for delivery	of this medic	cation.	y ι ux π.	
INITIAL REQUESTS					eranies? Check all that apply and record
<u> </u>	failure, contraindication, or intolera	ance of any o	other phar	nacologic and non-pharmacologic th	erapies? Check all that apply and record
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INITIAL REQUESTS 1. Does the patient have a history of trial and specific treatment/therapy. Submit docume non-drug treatment (list all):	failure, contraindication, or intolera ntation of treatments/therapies trie	ance of any o	other phar t be tried),	macologic and non-pharmacologic th dates and durations, and outcomes.	
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