Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Intra-Articular Hyaluronates

A. Prescriptions That Require Prior Authorization

All prescriptions for Intra-Articular Hyaluronates must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Intra-Articular Hyaluronate, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Intra-Articular Hyaluronate for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration-approved package labeling OR a medically accepted indication; **AND**

2. Has a documented history of therapeutic failure, contraindication, or intolerance to **all** of the following:

   a. Non-pharmacologic treatments,
   b. Acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs),
   c. Intra-articular glucocorticoid injection;

   AND

3. Does not have a contraindication to the requested agent; **AND**

4. For a non-preferred Intra-Articular Hyaluronate, has a history of therapeutic failure, contraindication, or intolerance of the preferred Intra-Articular Hyaluronates. See the Preferred Drug List (PDL) for the list of preferred Intra-Articular Hyaluronates at: https://papdl.com/preferred-drug-list

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR INTRA-ARTICULAR HYALURONATES: The determination of medical necessity of a request for renewal of a prior authorization for an Intra-Articular Hyaluronate that was previously approved will take into account whether the beneficiary:

1. Has documented improvement in pain or joint function following the first treatment; **AND**

2. Did not receive an Intra-Articular Hyaluronate in the same joint within the past 6 months; **AND**

3. Does not have a contraindication to the requested agent

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

B. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Intra-Articular Hyaluronate. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

C. Revisions to Dose and Duration of Therapy

Requests for prior authorization of an Intra-Articular Hyaluronate will be approved for one treatment course per knee.

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INTRA-ARTICULAR HYALURONATES PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other	

CLINICAL INFORMATION

Product requested:	Dosage form (syringe, vial, etc):

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.)*

Frequency of injection:	Requested duration of therapy:
Diagnosis:	Dx code (required):

INITIAL requests

Does the beneficiary 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: _____

_____

Requests for a non-preferred agent: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Intra-articular Hyaluronates? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.*	☐Yes – *Submit all supporting documentation of trial and failure, contraindications, & intolerances.* ☐No

RENEWAL requests

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

Record dates all previous Intra-Articular Hyaluronate injections. *SUBMIT CHART DOCUMENTATION of product used and dates of injections.*

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

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date: