Updated: 04/2019
PARP Approved: 04/2019

Prior Authorization Criteria

Synvisc and Synvisc One (intra-articular hyaluronan injection)

All requests for **Synvisc and Synvisc One (intra-articular hyaluronan injection)** require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of osteoarthritis of the knee and the following criteria is met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Documentation the member is experiencing knee pain that interferes with functional activities related to daily living
- The member must be 18 years and older
- Documentation of which knee(s) is/are being treated
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to all of the following conservative therapies. All must have been attempted and did not result in functional improvement (inadequate response) after at least 3 months:
    - Physical therapy or a physician directed exercise program.
    - Analgesics (acetaminophen) or NSAIDs.
    - Intra-articular corticosteroid injection
- **Initial Duration of Approval:** 1 month
- **Reauthorization criteria**
    - Coverage is provided for the other knee if the member has documented improvement in pain and functional capacity of the knee joint with the previous series of injections
    - Coverage is provided for the same knee or both knees if the member had significant improvement in pain and functional capacity of the knee joint with the previous series of injections, and the member's previous treatment was more than 6 months ago.
    - If the member's previous treatment wasn't more than six months ago, they must be a poor candidate for knee arthroplasty or other therapy due to age, physical or mental impairment.
- **Reauthorization Duration of approval:** 1 month

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

Updated: 04/2019
PARP Approved: 04/2019

SYNVISC/SYNVISC ONE (INTRA-ARTICULAR HYALURONAN INJECTION)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049

If needed, you may call to speak to a Pharmacy Services Representative.

PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Osteoarthritis of the knee ☐ Other: _____

If Osteoarthritis of the knee, which knee is affected? ☐ Right ☐ Left ☐ Both

Does the osteoarthritis interfere with activities of daily living? ☐ Yes ☐ No

Has the member failed to respond to physical therapy or a physician directed exercise program? ☐ Yes ☐ No

Has the member failed to respond or had an inadequate response to intraarticular steroid injections? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION			
The member had significant improvement in pain and functional capacity of the knee joint with previous injections? ☐ Yes ☐ No			
Is the member a poor candidate for knee arthroplasty or other therapy due to age, physical, or mental impairment? ☐ Yes ☐ No			
SUPPORTING INFORMATION or CLINICAL RATIONALE			

Prescribing Provider Signature	Date