Updated: 06/2023
DMMA Approved: 06/2023

Request for Prior Authorization for Intra-Articular Hyaluronan Injections
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Intra-Articular Hyaluronan Injections require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Intra-Articular Hyaluronan Injections Prior Authorization Criteria:

Coverage may be provided with a diagnosis of knee osteoarthritis 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
- The member must be 18 years of age or older
- Documentation the member is experiencing knee pain that interferes with functional activities related to daily living
- Documentation of which knee(s) is/are being treated (only 1 knee will be approved at a time)
- 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 physician directed exercise program.
    - Analgesics (acetaminophen) or NSAIDs (oral or topical).
    - Intra-articular corticosteroid injection
- Documentation showing the member has tried and failed or had an intolerance or contraindication to Synvisc or Synvisc One.

- **Initial Duration of Approval:** 1 treatment
- **Reauthorization criteria**
    - Coverage is provided for the other knee if the member had significant 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 patient'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 treatment

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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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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 Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158

If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
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

Has the member tried and failed or has a contraindication to Synvisc or Synvisc One? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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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