

## Prior Authorization Form

**HYALURONATES (FA-PA)**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at **1-888-836-0730**. Please contact CVS Caremark at **1-855-240-0536** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Monovisc (high molecular weight hyaluronan).

**Patient Information**

<b>Patient Name:</b>	<input type="text"/>
<b>Patient Phone:</b>	<input type="text"/>
<b>Patient ID:</b>	<input type="text"/>
<b>Patient Group No:</b>	<input type="text"/>
<b>Patient DOB:</b>	<input type="text"/>

**Prescribing Physician**

<b>Physician Name:</b>	<input type="text"/>
<b>Physician Phone:</b>	<input type="text"/>
<b>Physician Fax:</b>	<input type="text"/>
<b>Physician Address:</b>	<input type="text"/>
<b>City, State, Zip:</b>	<input type="text"/>

**Drug Name (specify drug):** Monovisc (high molecular weight hyaluronan)

<b>Quantity:</b>	<input type="text"/>	<b>Frequency:</b>	<input type="text"/>	<b>Strength:</b>	<input type="text"/>
<b>Route of Administration:</b>	<input type="text"/>	<b>Expected Length of Therapy:</b>	<input type="text"/>		
<b>Diagnosis:</b>	<input type="text"/>	<b>ICD Code:</b>	<input type="text"/>		
<b>Comments:</b>	<input type="text"/>				

**Please check the appropriate answer for each applicable question.**

- |   |   |                          |   |                          |
|---|---|--------------------------|---|--------------------------|
| 1. The preferred hyaluronate products for your patient's plan are Gel-One (cross-linked hyaluronate), Hyalgan (sodium hyaluronate) and Supartz FX (sodium hyaluronate). Is the prescriber willing to switch to one of the preferred products? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. Is the request for Monovisc?   | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. Is the patient in the middle of a treatment course (i.e., patient requires additional injection(s) to complete the current treatment course for the affected joint)?<br><u>Number of injections per treatment course</u>                   | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| • Euflexxa: 3 injections (2 mL each; 6 mL total) per course   |   |                          |   |                          |
| • Orthovisc: 3 or 4 injections (2 mL each; 8 mL total) per course   |   |                          |   |                          |
| 4. Has the patient tried and experienced an intolerable adverse event to all of the preferred products: Gel-One, Hyalgan and Supartz FX?  | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.

**Prescriber (Or Authorized) Signature and Date**

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