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 Orthovisc (high molecular weight hyaluronan).

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group No:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Prescribing Physician

Physician Name:

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Address:

City, State, Zip:

Drug Name (specify drug): Orthovisc (high molecular weight hyaluronan)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

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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** ☐ **N** ☐
2. Is the request for Monovisc? **Y** ☐ **N** ☐
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)? **Y** ☐ **N** ☐
   Number of injections per treatment course
   - 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** ☐ **N** ☐

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.

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Prescriber (Or Authorized) Signature and Date