



## Hyaluronate Products

### HMSAMCD - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Patient's Phone Number:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

#### Additional Demographic Information:

*Patient Weight:* \_\_\_\_\_ kg  
*Patient Height:* \_\_\_\_\_ ft \_\_\_\_\_ inches

#### *Indicate where the drug is being dispensed:*

- Office  Outpatient Hospital  Ambulatory Surgical  Inpatient Hospital
- Off Campus Outpatient Hospital  Urgent Care  Emergency Room  Birthing Center
- Military Facility  Skilled Nursing Facility  Nursing Facility  Hospice
- Inpatient Psychiatric  Psychiatric Residential Treatment  End Stage Renal Facility
- Psychiatric Facility  Pharmacy  Other

#### *Indicate where the drug is being administered:*

- Ambulatory surgical  Home  Inpatient Hospital
- Office  Outpatient Hospital  Pharmacy

What is the ICD-10 code? \_\_\_\_\_

**Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512**

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**Exceptions Criteria:**

A. What is the prescribed drug?

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> Durolane    | <input type="checkbox"/> Euflexxa, <i>Skip to Clinical Criteria</i> | <input type="checkbox"/> Gel-One                                       |
| <input type="checkbox"/> Gelsyn-3    | <input type="checkbox"/> Genvisc 850                                | <input type="checkbox"/> Hyalgan                                       |
| <input type="checkbox"/> Hymovis     | <input type="checkbox"/> Monovisc                                   | <input type="checkbox"/> Orthovisc                                     |
| <input type="checkbox"/> Supartz FX  | <input type="checkbox"/> Synvisc, <i>Skip to Clinical Criteria</i>  | <input type="checkbox"/> Synvisc One, <i>Skip to Clinical Criteria</i> |
| <input type="checkbox"/> Triluron    | <input type="checkbox"/> Trivisc                                    | <input type="checkbox"/> Visco-3                                       |
| <input type="checkbox"/> Other _____ |   |  |

B. The preferred hyaluronate products for your patient's health plan are Euflexxa, Synvisc, and Synvisc One. Can the patient's treatment be switched to one of the preferred products?

- Yes – Euflexxa *Skip to Clinical Criteria Questions*
- Yes – Synvisc *Skip to Clinical Criteria Questions*
- Yes – Synvisc One *Skip to Clinical Criteria Questions*
- No, *Continue to Question C*

C. 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)?

Number of injections per treatment course

- Gelsyn-3: 3 injections (2ml each, 6ml total) per course
- GenVisc 850: 3 to 5 injections (2.5 mL each; 12.5 mL total) per course
- Hyalgan: 3 to 5 injections (2 mL each; 10 mL total) per course
- Hymovis: 2 injections (3 mL each, 6 mL total) per course
- Orthovisc: 3 or 4 injections (2 mL each; 8 mL total) per course
- Supartz FX: 3 to 5 injections (2.5 mL each; 12.5 mL total) per course
- Triluron: 3 injections (2 mL each; 6 mL total) per course
- Trivisc: 3 injections (2.5 mL each, 7.5 mL total) per course
- Visco-3: 3 injections (2.5 mL each, 7.5 mL total) per course

- Yes – *Indicate dates of injections and affected joints below and No Further Questions*
- No, *Continue to Question D*

A) Date of Injection: _____	B) Affected Joint: _____
B) Date of Injection: _____	B) Affected Joint: _____
C) Date of Injection: _____	B) Affected Joint: _____
D) Date of Injection: _____	B) Affected Joint: _____

D. Has the patient experienced a documented intolerable adverse event to both of the preferred products (Euflexxa, Synvisc or Synvisc One)? **Action Required: If 'Yes', attach supporting chart note(s).**

- Yes, *Continue to Clinical Criteria Questions*
- No, *Continue to Clinical Criteria Questions*

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**Criteria Questions:**

1. What is the diagnosis?
  - Osteoarthritis of the knee (left or right knee), *Continue to #2*
  - Osteoarthritis of the knees (both), *Continue to #2*
  - Other, *Continue to #2*
  
2. Has the member received a previous course of intra-articular hyaluronate therapy for the knee joint?
  - Yes, *Continue to #13*
  - No, *Continue to #3*
  
3. Has the member tried and failed to respond adequately to 6 months of conservative therapy?
  - Yes, *Continue to #4*
  - No, *Continue to #4*
  
4. Please provide the conservative therapy tried and failed: \_\_\_\_\_ (fill in the blank), *Continue to #5*
  
5. Has the member failed to respond adequately to non-drug therapy (exercise program and strength training, and/or physical therapy, counseling regarding weight management if appropriate)?
  - Yes, *Continue to #6*
  - No, *Continue to #6*
  
6. Has the member tried and failed to respond to treatment with an oral/topical nonsteroidal anti-inflammatory drug (NSAID)?
  - Yes, *Continue to #7*
  - No, *Continue to #8*
  
7. Please provide the name of the NSAID previously tried and failed: \_\_\_\_\_ (fill in the blank)
  - Ibuprofen (Advil®, Motrin®), *Continue to #17*
  - Naproxen (Aleve®, EC Naprosyn®, Naprelan®), *Continue to #17*
  - Diclofenac (Cataflam®, Voltaren®, Arthrotec®), *Continue to #17*
  - Diflunisal, *Continue to #17*
  - Etodolac, *Continue to #17*
  - Flurbiprofen (Ansaid®), *Continue to #17*
  - Indomethacin, *Continue to #17*
  - Ketoprofen, *Continue to #17*
  - Meloxicam (Mobic®), *Continue to #17*
  - Nabumetone, *Continue to #17*
  - Oxaprozin (Daypro®), *Continue to #17*
  - Piroxicam (Feldene®), *Continue to #17*
  - Salsalate, *Continue to #17*
  - Other, *Continue to #8*
  
8. Does the member have a contraindication or history of intolerance to NSAIDs?

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- Yes, *Continue to #9*
- No, *Continue to #10*

9. Please provide the contraindication or intolerance: \_\_\_\_\_ (fill in the blank)

- History of intolerance or adverse event, *Continue to #17*
- Hypersensitivity, *Continue to #17*
- Significant drug interaction, *Continue to #17*
- Other, *Continue to #10*

10. Has the member tried and failed to respond to treatment with acetaminophen or tramadol?

- Yes, *Continue to #17*
- No, *Continue to #11*

11. Does the member have a contraindication or history of intolerance to acetaminophen or tramadol?

- Yes, *Continue to #12*
- No, *Continue to #12*

12. Please provide the contraindication or intolerance: \_\_\_\_\_ (fill in the blank)

- History of intolerance or adverse event, *Continue to #17*
- Hypersensitivity, *Continue to #17*
- Significant drug interaction, *Continue to #17*
- Other, *Continue to #17*

13. Did the member experience pain relief from this previous course of therapy?

- Yes, *Continue to #15*
- No, *Continue to #14*

14. Was the member unable to complete this previous course of therapy due to an adverse or allergic reaction?

- Yes, *Continue to #17*
- No, *Continue to #17*

15. Please provide the date of the last injection of the previous completed treatment course and the start date of the next planned course

- Last course start date: \_\_\_\_\_ MM/DD/YY, Next course start date: \_\_\_\_\_ MM/DD/YY, *Continue to #16*

16. Is the next planned start date at least 6 months after the date of the last injection of the previous completed treatment course?

- Yes, *Continue to #17*
- No, *Continue to #17*

17. What is the requested drug?

- Durolane, *No Further Questions*
- Euflexxa, *No Further Questions*
- Gel-One, *No Further Questions*
- Gelsyn-3, *No Further Questions*

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- GenVisc 850, *No Further Questions*
- Hyalgan, *No Further Questions*
- Hymovis, *No Further Questions*
- Hymovis One, *No Further Questions*
- Monovisc, *No Further Questions*
- Orthovisc, *No Further Questions*
- Supartz FX, *No Further Questions*
- Synojoynt., *No Further Questions*
- Synvisc, *No Further Questions*
- Synvisc One, *No Further Questions*
- Triluron, *No Further Questions*
- Trivisc, *No Further Questions*
- Visco-3, *No Further Questions*

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X** \_\_\_\_\_  
**Prescriber or Authorized Signature**

\_\_\_\_\_  
**Date (mm/dd/yy)**

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