Hyaluronate Products

HMSACOM - 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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

 MR Hyaluronate Products HMSACOM C13237-A, C20801-A – 04/2026.

Exceptions Criteria:

A. What is the prescribed drug?

❑ Durolane	❑ Euflexxa, *Skip to Clinical Criteria*	❑ Gel-One
❑ Gelsyn-3	❑ Genvisc 850	❑ Hyalgan
❑ Hymovis	❑ Monovisc	❑ Orthovisc
❑ Supartz FX	❑ Synvisc, *Skip to Clinical Criteria*	❑ Synvisc One, *Skip to Clinical Criteria*
❑ Triluron	❑ Trivisc	❑ Visco-3

❑ 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*

Clinical Criteria

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?
❒ 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*
❒ 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)**

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