



Viscosupplements

Orthovisc J7324, Monovisc J7327 & Synvisc [One] J7325 (Hyaluronate Sodium) are non-preferred. The preferred products are Euflexxa J7323, Hyalgan/Supartz J7321 (Hyaluronate Sodium), Gel-One J7326
No PA required for Preferred drugs.

Prior Authorization Step Therapy - Medicare Part B Request Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

| | |
|--------------------------|--|
| <input type="checkbox"/> | Date Requested _____ |
| | Requestor _____ Clinic name: _____ Phone _____ / Fax _____ |

MEMBER INFORMATION

*Name: _____ *ID#: _____ *DOB: _____

PRESCRIBER INFORMATION

*Name: _____ MD FNP DO NP PA *Phone: _____

*Address: _____ *Fax: _____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name: _____ Phone: _____

*Address: _____ Fax: _____

PROCEDURE / PRODUCT INFORMATION

| HCPC Code | Name of Drug <input type="checkbox"/> Self-administered | Dose (Wt: _____ kg Ht: _____) | Frequency | End Date if known |
|-----------|---|--------------------------------|-----------|-------------------|
| | | | | |

Chart notes attached. **Other important information:** _____

Diagnosis: ICD10: _____ **Description:** _____

Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

New Start or Initial Request: (Clinical documentation required for all requests)

Provider has reviewed the attached “Criteria for Approval” and attests the member meets ALL required PA criteria.

If not, please provide **clinical rationale** for formulary exception: _____

Continuation Requests: (Clinical documentation required for all requests)

Provider has reviewed the attached “Criteria for Continuation” and attests the member meets ALL required PA Continuation criteria.

Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

ACKNOWLEDGEMENT

Request By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.**

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

Prior Authorization Group – Viscosupplements Drugs PA

Drug Name(s):

| | |
|-----------------|-------------------|
| EUFLEXXA | MONOVISC |
| ORTHOVISC | SYNVISC |
| HYALGAN | SUPARTZ |
| HYALURONIC ACID | HYALURONIC SODIUM |
| GEL-ONE | |

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE of the formulary alternatives: **Hyalgan, Euflexxa, Supartz, Gel-One**
OR
 - There is clinical documentation stating formulary alternatives are contraindicated.
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
 - If the member meets all these criteria, they may be approved by the Plan for the requested drug.
 - Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Non-Preferred: Approval will be for 6 months

Preferred: No PA required.

FDA Indications:

Hyaluronic Sodium (all products):

- Cataract surgery; Adjunct
- Corneal transplant; Adjunct
- Filtering operation on eye; Adjunct
- Operative procedure on anterior chamber of eye; Adjunct
- Osteoarthritis of knee
- Retinal detachment repair; Adjunct
- Wound

Off-Label Uses:

Hyaluronic Sodium (all products):

- Arthropathy - Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

Step Therapy Drug(s) and FDA Indications:

See Above

Age Restrictions:

- Safety and effectiveness of intraocular injection in children have not been established
- safety and efficacy of intra-articular injection in pediatric patients have not been established, including patients younger than 21 years

Other Clinical Consideration:

Pre-existing hypocalcemia must be corrected prior to initiating therapy.

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/852E92/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/A9A3A8/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Hyaluronate%20Sodium&UserSearchTerm=Hyaluronate%20Sodium&SearchFilter=filterNone&navitem=searchGlobal#

https://careweb.careguidelines.com/ed24/ac/ac04_009.htm

CLINICAL / CMS ONLY