Reference number
1765-A

SPECIALTY GUIDELINE MANAGEMENT

DUROLANE (hyaluronic acid)
EUFLEXXA (1% sodium hyaluronate)
GEL-ONE (cross-linked hyaluronate)
GELSYN-3 (sodium hyaluronate 0.84%)
GENVISC 850 (sodium hyaluronate)
HYALGAN (sodium hyaluronate)
HYMOVIS (high molecular weight viscoelastic hyaluronan)
MONOVISC (high molecular weight hyaluronan)
ORTHOVISC (high molecular weight hyaluronan)
SUPARTZ (sodium hyaluronate)
SYNVISC (hylan G-F 20)
SYNVISC ONE (hylan G-F 20)
TRIVISC (sodium hyaluronate)
VISCO-3 (sodium hyaluronate)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication
Treatment of pain in osteoarthritis of the knee in patients who have failed to respond adequately to conservative non-pharmacologic therapy and simple analgesics (e.g., acetaminophen)

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Osteoarthritis (OA) of the Knee
Authorization of 6 months with an initial course of treatment with Synvisc ONE or Euflexxa may be granted for treatment of osteoarthritis (OA) in the knee when ALL the following criteria are met*

1. Member has an inadequate response to non-drug therapies (e.g., exercise, physical therapy, walking aids, insoles, and weight loss if applicable).
2. Member has an inadequate response to a pharmacologic treatment (i.e., acetaminophen, NSAID, COX2 inhibitor, or tramadol as defined by efficacy lasting less than 6-8 weeks.
3. Member has an inadequate response to intra-articular corticosteroid injection as defined by efficacy lasting less than 6-8 weeks.

4. Hyaluronate preparation is requested for member with Kellgreen-Lawrence Scale Grade 2 or greater osteoarthritis of the knee (radiologic confirmation required)
5. In addition to the criteria above, members who have previously received a course of treatment with any hyaluronate product must meet ONE of the following criteria:
   a. The next injection with the requested product is planned at least 6 months after the first injection of the last course of treatment.
   b. A different product is requested from the one used for the previous treatment due to an adverse reaction or
      insufficient response.

*****Treatment with other agents (e.g. GEL-ONE, GELSYN-3, GENVIS 850, HYALGAN, HYMOVIS, MONOVISC, ORTHOVISC, SUPARTZ, SYNVISC) covered only when above criteria are met, AND documentation confirms failure or contraindication to BOTH Euflexxa and Synvisc ONE.

I. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

II. REFERENCES

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9. Orthovisc [package insert]. Raynham, MA: DePuy Mitek, Inc.; June 2005.
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20. Conrozier T, Bertin P, Mathieu P, et al. Intra-articular injections of hylan G-F 20 in patients with symptomatic hip osteoarthritis: an open-label, multicenter, pilot study. *Clin Exp Rheumatol.* 2003;21:605-610.
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22. Neustadt DH. Intra-articular injections for osteoarthritis of the knee. *Cleve Clin J Med*. 2006;73(10):897-911.