Hyaluronates

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

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:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID**_____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: ❑ **Same as Requesting Provider** **HPHC Provider ID:**_____
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **Provider Tax ID:** _____

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

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

1. What is the diagnosis and ICD-10 code?
   ❑ Osteoarthritis of the knee (left)
   ❑ Osteoarthritis of the knee (right)
   ❑ Osteoarthritis of the knees (both)
   ❑ Other _____

   ICD-10 code: _____

2. What is the requested drug?
   ❑ Euflexxa, *skip to #7* ❑ Gel-One ❑ Gelsyn-3 ❑ GenVisc 850 ❑ Hyalgan ❑ Hymovis
   ❑ Monovisc ❑ Orthovisc ❑ Supartz ❑ Synvisc One, *skip to #7* ❑ Synvisc
   ❑ Other_____

3. Has the patient previously received treatment with Synvisc One OR Euflexxa? ❑ Yes ❑ No *If No, skip to #5*

4. Has the patient experienced any of the following during treatment with Synvisc One OR Euflexxa?
   If yes, please attach supporting documentation and skip to #6.
   ❑ Yes – Inadequate response
   ❑ Yes – Intolerable adverse event (e.g., hypersensitivity reaction)
   ❑ No

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

 Hyaluronates HPHC – 04/2018.

5. Does the patient have a contraindication to Synvisc One OR Euflexxa?
   If yes, please attach supporting documentation. ❑ Yes ❑ No

6. Will documentation supporting ANY of following be attached? ❑ Yes ❑ No
   - Inadequate response
   - Intolerable adverse event
   - Contraindication to Synvisc One or Euflexxa therapy

7. What is the member's osteoarthritis (of the knee) grade level according to the Kellgren-Lawrence Grading Scale?
   Please attach documentation supporting the grade level (i.e., radiology reports).
   ❑ Grade 1 (doubtful narrowing of joint space and possible osteophytic lipping)
   ❑ Grade 2 (definite osteophytes and possible narrowing of joint space)
   ❑ Grade 3 (moderate multiple osteophytes, definite narrowing of joint space, some sclerosis and possible deformity of bone contour)
   ❑ Grade 4 (large osteophytes, marked narrowing of joint space, severe sclerosis and definite deformity of bone contour)

8. Will documentation supporting the member's Kellgren-Lawrence grade level be attached? ❑ Yes ❑ No

9. Has the patient had an inadequate response to non-drug therapies (eg, exercise, weight loss if applicable, physical therapy, walking aids, insoles)? ❑ Yes ❑ No

10. Has the patient had an inadequate response (i.e., efficacy of treatment lasted less than 6 weeks) to any of the following drug therapies? ❑ Yes ❑ No
    - Acetaminophen (Tylenol®)
    - Nonsteroidal anti-inflammatory drug (NSAID)
    - Cyclooxygenase-2 (COX2) inhibitor
    - Tramadol (Ultram®)
    - Intra-articular corticosteroid injection

11. Please indicate therapies previously tried and failed:

    _____

12. Has the patient previously received treatment with any intra-articular hyaluronate product?
    ❑ Yes ❑ No *If No, no further questions*

13. Please specify the following:
    Brand name of the product: _____

    The site of injection: _____

    The date of the first injection of the last course of treatment: _____

    The date of last injection: _____

    Any adverse reactions (if applicable): _____

14. Please specify the date of the next planned injection: _____

15. Is the next injection with the requested product planned at least 6 months after the first injection of the last course of treatment with any intra-articular hyaluronate product? *If Yes, skip to #18* ❑ Yes ❑ No

16. Are both of the following criteria met? *If Yes, skip to #18* ❑ Yes ❑ No
    - The request is for the treatment of a different joint
    - The next injection is planned at least 6 months after the first injection of the last course of treatment with any intra-articular hyaluronate product for this joint

17. Are both of the following criteria met? *If Yes, no further questions* ❑ Yes ❑ No
    - The patient experienced an adverse reaction to the hyaluronate product used for the previous treatment
    - The requested product is different from the one used for the previous treatment

18. Is the request for continuation of therapy with the same product? ❑ Yes ❑ No *If No, no further questions*

19. Has the patient received a full course of treatment with the requested product for the same joint? ❑ Yes ❑ No
    Course of therapy for intra-articular hyaluronate products
    - Euflexxa: 3 injections (2 mL each; 6 mL total)
    - Gel-One: 1 injection (3 mL each; 3 mL total)
    - Gelsyn-3: 3 injections (2 mL each, 6 mL total)
    - GenVisc 850: 3 to 5 injections (2.5 mL each; 12.5 mL total)
    - Hyalgan: 3 to 5 injections (2 mL each; 10 mL total)
    - Hymovis: 2 injections (3 mL each, 6 mL total)
    - Monovisc: 1 injection (4 mL each, 4 mL total)
    - Orthovisc: 3 or 4 injections (2 mL each; 8 mL total)
    - Supartz: 3 to 5 injections (2.5 mL each; 12.5 mL total)
    - Synvisc One: 1 injection (6 mL each; 6 mL total)
    - Synvisc: 3 injections (2 mL each; 6 mL total)

20. Did the patient experience pain relief from this previous course of therapy? ❑ Yes ❑ No

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: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882