Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Part B ST - Sodium Hyaluronates

Phone: 215-991-4300 Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: ☐ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the product being requested for the treatment of osteoarthritis of the knee?

☐ Yes ☐ No

Q2. The preferred hyaluronate products are Orthovisc, Synvisc, and Synvisc One. Can the patient's treatment be switched to one of the preferred products?

☐ Yes ☐ No

Q3. Has the patient received treatment with the requested product in the past 365 days?
If YES, indicate date of the injection and affected joint in Additional Information.

☐ Yes ☐ No

Q4. Has the patient experienced a documented intolerable adverse event to at least two of the preferred products: A) Orthovisc and B) Synvisc or Synvisc One?
Please attach supporting chart note(s).

☐ Yes ☐ No

Q5. Is the diagnosis supported by radiographic evidence of osteoarthritis of the knee, such as joint space narrowing, subchondral sclerosis, osteophytes, and sub-chondral cysts?
If Yes, go to 7.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. At the time of diagnosis, did/does the patient have at least 5 of the following signs and symptoms?
A) Bony enlargement
B) Bony tenderness
C) Crepitus (noisy, grating sound) on active motion
D) Erythrocyte sedimentation rate (ESR) less than 40 mm/hr
E) Less than 30 minutes of morning stiffness
F) No palpable warmth of synovium
G) Over 50 years of age
H) Rheumatoid factor less than 1:40 titer (agglutination method)
I) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3)

☐ Yes ☐ No

Q7. Does the patient have knee pain which interferes with functional activities (e.g., ambulation, prolonged standing)?

☐ Yes ☐ No

Q8. Has the patient experienced an inadequate response or adverse effects with non-pharmacologic treatment options (e.g., physical therapy, regular exercise, insoles, knee bracing, weight reduction)?

☐ Yes ☐ No

Q9. Has the patient experienced an inadequate response or intolerance to a trial of an analgesic (e.g., acetaminophen up to 3 to 4 grams per day, non-steroidal anti-inflammatory drugs [NSAIDs], topical capsaicin cream) for at least 3 months?
If Yes, go to 11.

☐ Yes ☐ No

Q10. Does the patient have a contraindication to a trial of an analgesic (e.g., acetaminophen up to 3 to 4 grams per day, non-steroidal anti-inflammatory drugs [NSAIDs], topical capsaicin cream) for at least 3 months?

☐ Yes ☐ No

Q11. Has the patient experienced an inadequate response or intolerance to a trial of intraarticular steroid injections for at least 3 months?
If Yes, go to 13.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q12. Does the patient have a contraindication to a trial of intraarticular steroid injections for at least 3 months?

☐ Yes ☐ No

Q13. Is the patient scheduled to undergo a total knee replacement within 6 months of starting treatment?

☐ Yes ☐ No

Q14. Is the request for continuation of treatment with the requested hyaluronate product?

☐ Yes ☐ No

Q15. Has the patient experienced improvement in pain and functional capacity following the previous injections?

☐ Yes ☐ No

Q16. Additional Information:

Q17. Requested Duration:

☐ 12 months

Prescriber Signature

Date

2024 Medicare Prior Authorization Request