Hyaluronates Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____ ☐ Continuation of therapy (Request Additional Series Below)

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Orthopedic** ☐ **Primary Provider** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for:

- ☐ Euflexxa (1% sodium hyaluronate)
- ☐ Durolane (hyaluronic acid)
- ☐ Gel-One (cross-linked hyaluronate)
- ☐ Gelsyn-3 (sodium hyaluronate)
- ☐ GenVisc 850 (sodium hyaluronate)
- ☐ Hyalgan (sodium hyaluronate)
- ☐ Hymovis (high molecular weight viscoelastic hyaluronan)
- ☐ Monovisc (sodium hyaluronate)
- ☐ Orthovisc (high molecular weight hyaluronan)
- ☐ Supartz FX (sodium hyaluronate)
- ☐ Synojoynt (1% sodium hyaluronate)
- ☐ Synvisc (hylan G-F 20)
- ☐ Synvisc-One (hylan G-F 20)
- ☐ Triluron (sodium hyaluronate)
- ☐ TriVisc (sodium hyaluronate)
- ☐ Visco-3 (sodium hyaluronate)
- ☐ 1% sodium hyaluronate

Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (includes Medicare patient requests, clinical documentation required for all requests):

☐ Yes ☐ No Has the patient been diagnosed with osteoarthritis (OA) of the knee?

☐ Yes ☐ No Is the diagnosis supported by radiographic evidence of osteoarthritis of the knee, such as joint space narrowing, subchondral sclerosis, osteophytes, and sub-chondral cysts?

→ ☐ Yes ☐ No At the time of diagnosis, did/does the patient have at least 5 of the following signs and symptoms?

Select all that apply:

- ☐ Bony enlargement
- ☐ Bony tenderness
- ☐ Crepitus (noisy, grating sound) on active motion
- ☐ Erythrocyte sedimentation rate (ESR) less than 40 mm/hr
- ☐ Less than 30 minutes of morning stiffness
- ☐ No palpable warmth of synovium
- ☐ Over 50 years of age
- ☐ Rheumatoid factor less than 1:40 titer (agglutination method)
- ☐ Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3)

☐ Yes ☐ No Does the patient have knee pain that interferes with functional activities (e.g., ambulation or prolonged standing)?

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FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please use Medicare Request Form

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No 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 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?

→ ☐ Yes ☐ No 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 Has the patient experienced an inadequate response or intolerance to a trial of intraarticular steroid injections for at least 3 months?

→ ☐ Yes ☐ No Does the patient have a contraindication to a trial of intraarticular steroid injections for at least 3 months?

☐ Yes ☐ No Is the patient scheduled to undergo a total knee replacement within 6 months of starting treatment?

☐ Yes ☐ No Is this request for Orthovisc, Synvisc or Synvisc-One?

→ ☐ Yes ☐ No Has the patient received Orthovisc in the past?

→ ☐ Yes ☐ No Does the patient have a documented intolerance to Orthovisc?

→ ☐ Yes ☐ No Does the patient have a documented contraindication to Orthovisc?

☐ Yes ☐ No Has the patient received Synvisc in the past?

→ ☐ Yes ☐ No Does the patient have a documented intolerance to Synvisc?

→ ☐ Yes ☐ No Does the patient have a documented contraindication to Synvisc?

☐ Yes ☐ No Has the patient received Synvisc-One in the past?

→ ☐ Yes ☐ No Does the patient have a documented intolerance to Synvisc-One?

→ ☐ Yes ☐ No Does the patient have a documented contraindication to Synvisc-One?

For Medicare Patient Requests Only:

☐ Yes ☐ No Does the patient have morning stiffness of less than 30 minutes in duration?

☐ Yes ☐ No Does the patient have crepitus on motion of the knee?

For All Additional Series Requests (includes Medicare patient requests, clinical documentation required for all requests):

What product did the patient last receive? _____

Enter date of last injection from prior series: ____/____/____

☐ Yes ☐ No Was the previous series of injections completed at least 3 months prior to this request?

☐ Yes ☐ No Has the patient experienced improvement in pain and functional capacity following previous injections?

Additional Series Requests For Medicare Patient Only:

☐ Yes ☐ No Has at least 6 months elapsed since the beginning of the prior series of injections?

☐ Yes ☐ No ☐ N/A Was there a reduction in the number of intra-articular steroid injections or aspirations during the 6-month period following the series?

H. ACKNOWLEDGEMENT

Request Completed 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.

The plan may request additional information or clarification, if needed, to evaluate requests.