aetna®

Viscosupplementation Injectable Medication Precertification Request

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

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

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 ☐ Mail Order

☐ Other: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ Euflexxa ☐ Gel-One ☐ Gel-Syn ☐ GenVisc 850 ☐ Hyalgan ☐ Hymovis
☐ Orthovisc ☐ Monovisc ☐ Supartz ☐ Synvisc ☐ Synvisc One

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):

☐ Yes ☐ No Does the patient have documented symptomatic osteoarthritis (OA) of the tibiofemoral articulation of the knee?
→ Which knee will the viscosupplement be used? ☐ Left knee ☐ Right knee ☐ Both knees

☐ Yes ☐ No Is there radiologic evidence of osteoarthritis of the knee?
→ Which of the following documented symptoms of osteoarthritis (OA) does the patient have? (Check ALL that apply)
☐ Knee Pain ☐ 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
→ Which of the following radiologic findings support the clinical diagnosis of osteoarthritis (OA)?
☐ Joint space narrowing ☐ Subchondral sclerosis ☐ Osteophytes and sub-chondral cysts ☐ Other: _____
What is the date the radiologic testing was completed? ____/____/____

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

☐ Yes ☐ No Can the knee pain be attributed to any other forms of joint disease (other than osteoarthritis)?

☐ Yes ☐ No Has the patient completed at least 3 months of conservative therapy in each joint to be treated with viscosupplementation?
→ ☐ Yes ☐ No Is the patient unable to tolerate conservative therapy because of adverse side effects?
Specify the intolerance to conservative therapy: _____
→ Please indicate which of the following conservative therapies the patient completed:
☐ Physical therapy ☐ Acetaminophen ☐ Topical capsaicin cream ☐ NSAID's, Specify: _____
☐ Other, Explain: _____
Enter the date range of the conservative treatment regimen: ____/____/____ to ____/____/____
☐ Yes ☐ No Has the conservative treatment resulted in functional improvement after 3 months of therapy?

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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 failed to adequately respond to aspiration and injection of intra-articular steroids?
→ Please explain the patient's failed response: _____
Enter the date(s) of the aspiration and injection of intra-articular steroids: ___/___/___ , ___/___/___ , ___/___/___

☐ Yes ☐ No Are there any contraindications to the patient receiving viscosupplementation injections?
→ Which of the following contraindications apply: ☐ Coagulopathy ☐ Egg hypersensitivity ☐ Hemophilia ☐ Infection ☐ Skin disease

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

☐ Yes ☐ No Has the patient tried and failed all 3 of the following viscosupplements: Euflexxa, Monovisc, and Orthovisc?

☐ Yes ☐ No Was the treatment with Euflexxa ineffective?
→ ☐ Yes ☐ No Does the patient have a documented intolerance to Euflexxa? ***If yes,*** Please describe: _____
☐ Yes ☐ No Does the patient have a documented contraindication to Euflexxa? ***If yes,*** Please describe: _____
→ Please provide the dates of previous trial of Euflexxa:
Injection #1: ___/___/___ Injection #2: ___/___/___ Injection #3: ___/___/___

☐ Yes ☐ No Was the treatment with Monovisc ineffective?
→ ☐ Yes ☐ No Does the patient have a documented intolerance to Monovisc? ***If yes,*** Please describe: _____
☐ Yes ☐ No Does the patient have a documented contraindication to Monovisc? ***If yes,*** Please describe: _____
→ Please provide the date of the previous Monovisc injection: ___/___/___

☐ Yes ☐ No Was the treatment with Orthovisc ineffective?
→ ☐ Yes ☐ No Does the patient have a documented intolerance to Orthovisc? ***If yes,*** Please describe: _____
☐ Yes ☐ No Does the patient have a documented contraindication to Orthovisc? ***If yes,*** Please describe: _____
→ Please provide the dates of previous trial of Orthovisc:
Injection #1: ___/___/___ Injection #2: ___/___/___ Injection #3: ___/___/___ Injection #4: ___/___/___

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) :

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

What product did the patient last receive? _____

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

☐ Yes ☐ No Has the patient had a documented reduction in the dose of NSAID's, other anti-inflammatories, or other analgesics during the 3 month period following the previous injection series?
→ ☐ Yes ☐ No Does the patient require of NSAID's, other anti-inflammatories, or other analgesics for a comorbid medical condition in addition to OA for the knee? ***If yes,*** please identify the comorbid medical condition: _____

☐ Yes ☐ No Is there objective documentation to support significant improvement of functional capacity as a result of previous injection series?

☐ Yes ☐ No Is there objective documentation to support significant improvement in pain as a result of 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.