MEDICARE FORM

Viscosupplementation Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
PHONE: 1-866-503-0857
FAX: 1-844-268-7263

For other lines of business:
Please use other form.

Note: Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc, Hyalgan, Hymovis, Monovisc, Supartz, TriVisc and Visco-3 are non-preferred. The preferred products are Orthovisc, Synvisc, and Synvisc One.

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: _____

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:
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ *Outpatient Dialysis Center* ☐ Physician's Office
☐ Retail Pharmacy ☐ Specialty Pharmacy
☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

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) ☐ Supartz FX (sodium hyaluronate)
☐ Hymovis (high molecular weight viscoelastic hyaluronan) ☐ Orthovisc (high molecular weight hyaluronan) ☐ Monovisc (sodium hyaluronate)
☐ Synvisc (hylan G-F 20) ☐ Synvisc-One (hylan G-F 20) ☐ TriVisc (sodium hyaluronate) ☐ Visco-3 (sodium hyaluronate)
☐ Synojoynt (1% sodium hyaluronate) ☐ Triluron (1% sodium hyaluronate)

Dose: _____ **Frequency:** _____ **HCPCS Code:** _____

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):

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☐ Yes ☐ No Has the patient had prior therapy with the requested viscosupplementation product within the last 365 days?
☐ Yes ☐ No Has the patient had an intolerance or contraindication to Orthovisc, Synvisc, or Synvisc One?
Please explain if there are any other medical reason(s) that the patient cannot use Orthovisc, Synvisc, or Synvisc One

_____

_____

☐ 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

Continued on next page

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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 Is there radiologic evidence of osteoarthritis (OA) of the knee?
→ ☐ Yes ☐ No Is the patient symptomatic?
→ 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)?
Please select: ☐ Joint space narrowing ☐ Subchondral sclerosis ☐ Osteophytes and sub-chondral cysts

☐ 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 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?
→ Please indicate which of the following conservative therapies the patient completed:
☐ Physical therapy ☐ Acetaminophen ☐ Topical capsaicin cream ☐ NSAID's, Specify: _____
☐ Other: please explain: _____

☐ Yes ☐ No Has the conservative treatment resulted in functional improvement after therapy?
☐ Yes ☐ No Has the patient failed to adequately respond to aspiration and injection of intra-articular steroids?
☐ Yes ☐ No Are there any contraindications to the patient receiving viscosupplementation injections (e.g. active joint infection, bleeding disorder or skin infections at the injection site)?
☐ Yes ☐ No Is the patient scheduled to undergo a total knee replacement within 6 months of starting viscosupplementation treatment?
☐ Yes ☐ No Will the drug requested be used concomitantly with any of the following?
→ Please select: ☐ With intra-articular anesthetics ☐ With intra-articular corticosteroids ☐ With intra-articular platelet rich plasma
☐ With intra-articular mannitol/sorbitol ☐ With intra-articular mesenchymal stem cells ☐ With another viscosupplement
☐ 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 (clinical documentation required for all requests):
What product did the patient last receive? _____
Enter date of last injection from prior series: ____/____/____
☐ Yes ☐ No Have at least six months elapsed since the last injection in the prior series?
☐ Yes ☐ No Has the patient had a documented reduction in the dose of NSAID's, other anti-inflammatories, or other analgesics during the 6-month period following the previous injection series?
→ ☐ Yes ☐ No Does the patient require NSAID's, other anti-inflammatories, or other analgesics for a comorbid medical condition in addition to OA of the knee? **If yes,** please identify the comorbid medical condition: _____
☐ 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?
☐ 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?

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.