



# Hyaluronates Injectable Medication Precertification Request

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(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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #:	If yes, provide ID#:	Carrier Name:
Insured:	Insured:	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		

### C. PRESCRIBER INFORMATION

First Name:		Last Name:			(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.		
Address:		City:	State:	ZIP:			
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:		
Provider Email:		Office Contact Name:			Phone:		
Specialty (Check one): <input type="checkbox"/> Orthopedic <input type="checkbox"/> Primary Provider <input type="checkbox"/> Other: _____							

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b>		<b>Dispensing Provider/Pharmacy:</b> <i>Patient Selected choice</i>	
<input type="checkbox"/> Self-administered	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Retail Pharmacy
<input type="checkbox"/> Outpatient Infusion Center	Phone: _____	<input type="checkbox"/> Specialty Pharmacy	<input type="checkbox"/> Other _____
Center Name: _____		Name: _____	
<input type="checkbox"/> Home Infusion Center	Phone: _____	Address: _____	
Agency Name: _____		Phone: _____	Fax: _____
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____	PIN: _____
Address: _____			

### E. PRODUCT INFORMATION

**Request is for:**

<input type="checkbox"/> Euflexxa (1% sodium hyaluronate)	<input type="checkbox"/> Hymovis (high molecular weight viscoelastic hyaluronan)	<input type="checkbox"/> Synvisc (hylan G-F 20)
<input type="checkbox"/> Durolane (hyaluronic acid)	<input type="checkbox"/> Monovisc (sodium hyaluronate)	<input type="checkbox"/> Synvisc-One (hylan G-F 20)
<input type="checkbox"/> Gel-One (cross-linked hyaluronate)	<input type="checkbox"/> Orthovisc (high molecular weight hyaluronan)	<input type="checkbox"/> Trilon (sodium hyaluronate)
<input type="checkbox"/> Gelsyn-3 (sodium hyaluronate)	<input type="checkbox"/> Supartz FX (sodium hyaluronate)	<input type="checkbox"/> TriVisc (sodium hyaluronate)
<input type="checkbox"/> GenVisc 850 (sodium hyaluronate)	<input type="checkbox"/> Synojoynt (1% sodium hyaluronate)	<input type="checkbox"/> Visco-3 (sodium hyaluronate)
<input type="checkbox"/> Hyalgan (sodium hyaluronate)		<input type="checkbox"/> 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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For Medicare Advantage Part B:  
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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**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 continuation of a current series or the re-start of a new series (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 6 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.