



Hyaluronic Acid Injections Prior Authorization Form

Priority: Standard Expedited

Member Information	Member Name:		DOB:	
	Address:		Member ID:	
	Primary Insurance:		Secondary Insurance:	
	ID #:	Group #:	ID #:	Group #:
Medication Information	Supartz/Hyalgan/Visco-3 (J7321) GelSyn-3 (J7328) Durolane (J7318) Synvisc/Synvisc-One (J7325) Euflexxa (J7323) Monovisc (J7327) Orthovisc (J7324) Gel-One (J7326) Other:			
	Directions for Use:		Injection Site: Right Knee Left Knee Both Knees Other: _____	
	Admin. Dates: _____ to _____		HT: WT: BMI:	
Statements of Medical Necessity	Primary Diagnosis (ICD-10 Code and Description):			
	<input type="checkbox"/> YES <input type="checkbox"/> NO Is there radiological evidence (x-ray or MRI) to support osteoarthritis? Attach documentation. <input type="checkbox"/> YES <input type="checkbox"/> NO Has the patient received intra-articular corticosteroid injections? If YES, list date(s): _____ <input type="checkbox"/> YES <input type="checkbox"/> NO Is the patient's BMI ≥ 30 ? If YES, indicate weightloss (lbs) or lifestyle modification attempts (examples: diet, exercise, etc.): _____ <input type="checkbox"/> YES <input type="checkbox"/> NO Has the patient attempted three months of bracing/orthotics or physical/occupational therapy? If YES, indicated attempts and date range: _____ If prescribing a non-preferred medication, indicate clinical reason*: _____ *Please attach documentation to support reason.			
Medication History	A. Is member currently treated on this medication? <input type="checkbox"/> YES ; How long? _____ <input type="checkbox"/> NO		B. Does the patient have an allergy to avian proteins, feathers or egg products? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	<input type="checkbox"/> YES <input type="checkbox"/> NO Has the patient been treated with a Hyaluronic Acid Derivative injection in the past?	Medication	Injection site(s)	Dates of Therapy
	<input type="checkbox"/> YES <input type="checkbox"/> NO Has the patient failed at least three simple analgesics (i.e. NSAIDs, acetaminophen, oral or topical salicylates)?	Medication	Start Date	End Date
Servicing Provider Information	Place of Service: <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Outpatient Facility <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Member's Home	Servicing Provider Name:		
		Address:		
		City/State/Zip:		CareSource ID:
		Office Contact:		Phone: Fax:
		Tax ID:		NPI #:
Prescribing Provider Information	Prescriber Name:		Prescriber Speciality:	
	Address:		Tax ID:	
	City/State/ZIP:		NPI #:	
	Office Contact:		Phone:	Fax:
	Prescriber Signature:		Date:	

Fax completed form and clinical documentation to 1-888-399-0271. Questions? Call: 1-800-488-0134.

Please refer to the corresponding pharmacy policy on www.CareSource.com. Eligibility of the member at the time of service and timely claim filing limits. Authorizations are not a guarantee of payment and are contingent upon eligibility and benefits.