

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-844-723-2094. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.

Drug Requested (check applicable drug below): (Hyaluronate Acids) (Medical)

<u>Preferred:</u>	<u>Non-Preferred:</u>
<input type="checkbox"/> Euflexxa® (J7323) <input type="checkbox"/> Synvisc®/Synvisc-One® (J7325)	<input type="checkbox"/> Hyalgan® (J7321) <input type="checkbox"/> Supartz® (J7321) <input type="checkbox"/> Gel-One® (J7326) <input type="checkbox"/> Monovisc® (J7327) <input type="checkbox"/> Orthovisc® Injections (J7324) <input type="checkbox"/> Gel-Syn® (J7328) <input type="checkbox"/> Genvisc® (J7320/Q9980) <input type="checkbox"/> Hymovis® (J7322/C9471 NDC 89122-0496-63)

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Name/Form: _____ Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Medical notes must be submitted to support each line checked on this request.

Medication being provided by the physician's office

CLINICAL CRITERIA: Check the applicable diagnosis. Boxes **MUST** be checked to ensure the authorization process will **NOT** be delayed.

Please check ALL below for OA indication:

- Has the member tried and failed: Euflexxa® or Synvisc® or Synvisc-One®

Section I: (all criteria must be met)

- Patient has diagnosis of Osteoarthritis of the
 Left knee and/or Right knee

AND

- Documented NSAIDS use, length of time taken and/or failure of NSAID and/or patient is not a candidate for NSAID therapy

AND

- Failure of steroid injection or adverse reaction to steroids (Failure defined as relief from injection lasting ≤ 2 months)

AND

- Weight-bearing x-ray with noted joint space narrowing and/or osteophytes (i.e. bone spurs)

AND

- Documented significant pain and/or limitation of function over the past 6 months.

Please check ALL below for TMJ indication:

- Has the member tried and failed: Euflexxa® or Synvisc® or Synvisc-One®

(All criteria must be met)

- Patient has diagnosis of TMJ
 Documented osteoarthritis or disc displacement of the TMJ
 Failure of conventional therapies (nonprescription analgesics, physical therapy, occlusal alignment, bite plates, etc.)
 Documented significant pain and/or disability

(signature on next page)

- Hyalgan®, Synvisc®, Supartz®, Euflexxa®, Gel-One®, Orthovisc®, Gel-Syn®, and Genvisc® coverage is **excluded** in patients with bone-on-bone (no cartilage present) pain.
- Synvisc–One® is limited to **ONE** office visit.

*****Use of samples to initiate therapy does not meet step edit/preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____
Member Optima #: _____ Date of Birth: _____
Prescriber Name: _____
Prescriber Signature: _____ Date: _____
Office Contact Name: _____
Phone Number: _____ Fax Number: _____
DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018