OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 1-844-348-3720**. 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**.

Hyaluronate Acids (Medical)

Drug Requested (check applicable drug below)**:**

Preferred:	**Non-Preferred:**
❑ **Euflexxa®** (J7323)	❑ **Hyalgan®** (J7321) ❑ **Supartz®** (J7321) ❑ **Gel-One®** (J7326)
❑ **Synvisc®/Synvisc-One®** (J7325)	❑ **Monovisc®** (J7327) ❑ **Orthovisc®** Injections (J7324)
	❑ **Gel-Syn®** (J7328) ❑ **Genvisc®** (J7320/Q9980)
	❑ **Hymovis®** (J7322/C9471 NDC 89122-0496-63)

DRUG INFORMATION: Complete 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 qualify to ensure authorization 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

_____

- **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: ~~8/1/2017; 8/22/2018;~~ **10/8/2018**