OPTIMA HEALTH 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 1-844-723-2094**. 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**.

Hyaluronate Acids (Medical)

Drug Requested (check applicable drug below):			
PREFERRED:			
❑ **Euflexxa® (J7323)**		❑ **Synvisc®/Synvisc-One® (J7325)**	
Non-Preferred:			
❑ **Hyalgan® (J7321)**	❑ **Supartz® (J7321)**	❑ **Gel-One® (J7326)**	❑ **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.

❑ **Has member tried and failed both Euflexxa® and Synvisc® or Synvisc-One®?** ❑ Yes ❑ No

❑ **For Osteoarthritis (OA) indications:** Please check below **ALL** that apply. **ALL** criteria **MUST** be met to qualify.

❑ Patient has diagnosis of **Osteoarthritis** of the **(check box below that applies)**:

❑ 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

(continued on next page)

- ❑ 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.

  ____

❑ **For TMJ (temporomandibular joints) indications:** **ALL** criteria below **MUST** be met to qualify or authorization will be delayed.

Please check ALL below for TMJ indication:

- ❑ 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;~~ **(Reformatted) 2/5/2019**