

OPTIMA HEALTH COMMUNITY 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:			
<input type="checkbox"/> Euflexxa® (J7323)		<input type="checkbox"/> Synvisc®/Synvisc-One® (J7325)	
Non-Preferred:			
<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 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 \leq 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