# OPTIMA HEALTH COMMUNITY CARE

## 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.***

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

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

***DRUG INFORMATION: Complete information below. Incomplete information will delay authorization process.***

**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. Incomplete information will delay authorization process.***

### 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: 8/1/2017**