OPTIMA HEALTH PLAN

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 1-844-202-5034. 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)**	❑ **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. Incomplete information will delay authorization process.

****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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 9/02/2010
REVISED/UPDATED: ~~6/10/2011; 4/19/2012; 5/3/2012; 1/17/2014; 4/3/2014; 10/31/2014; 1/26/2015; 1/29/2015; 4/3/2015; 5/23/2015; 8/11/2015; 12/22/2015; 1/29/2016; 3/31/2016; 6/9/2016; 8/19/2016; 9/22/2016; 12/28/2016; 4/1/2017;~~ **9/14/2017**;