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)(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. 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. Chart notes, lab values, etc. MUST be attached to this request form.*

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

Please check *ALL* below for OA indication:

Section I: (*all* criteria *must* be met)

- ❑ Patient has diagnosis of Osteoarthritis of the:
  - ❑ Left knee and/or ❑ Right knee

AND

- ❑ Weight-bearing x-ray with noted joint space narrowing and/or osteophytes (i.e. bone spurs)

Please check *ALL* below for TMJ indication:

(*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 #: _____

***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;~~ **1/23/2018**