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 1-844-723-2094. 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.***

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

Preferred:	***Non-Preferred:***
❑ **Euflexxa®** **(J7323)** ❑ **Synvisc®/Synvisc-One®** **(J7325)**	❑ **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.

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 #: ____

***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; **7/24/2017**;