

Today's date: \_\_\_\_\_

Intended date of injection: \_\_\_\_\_

**Prior Authorization Form – Viscosupplementation (Hyaluronic Acid Products)**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED.**

**PREFERRED BRANDS DO NOT REQUIRE PRIOR AUTHORIZATION: Monovisc®, Orthovisc®, Synvisc®, Synvisc-One®**

**Select one:**  Durolane®  Euflexxa®  Gel-One®  Gelsyn-3™  GenVisc850®  Hyalgan®  
 Hymovis®  Supartz®  Synjoynt™  Triluron™  TriVisc™  VISCO-3™

**Check one:**  New start  Continued treatment (skip questions 2a-k): Please fax progress notes of prior injections.

**Patient information (please print)**

**Physician information (please print)**

Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of birth	Fax #	NPI

**Authorization is required for Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc850, Hyalgan, Hymovis, Supartz, Synjoynt, Triluron, TriVisc, and VISCO-3.**

**1) Diagnosis for drug requested (must include ICD-10):** \_\_\_\_\_  Knee:  Right  Left  Bilateral

**2) Patient medical information**

- a. Does the patient have documented symptomatic osteoarthritis of the knee?  Yes  No
- b. Is the patient's knee pain associated with radiographic evidence of osteophytes in the knee joint?  Yes  No
- c. Is there sclerosis on a bone adjacent to the knee?  Yes  No
- d. Is there joint space narrowing?  Yes  No
- e. Does the patient have morning stiffness that lasts less than 30 minutes in duration?  Yes  No
- f. Does the patient have knee pain that interferes with functional activities (e.g., walking, prolonged standing)?  Yes  No
- g. Can the patient's knee pain be attributed to other forms of joint disease?  Yes  No
- h. Is there documentation that the patient does not have functional improvement after at least a 3-month trial of conservative treatment such as exercise, physical therapy, and nonsteroidal anti-inflammatory drugs (NSAIDs)?  Yes  No
- i. Has the patient been treated with intra-articular corticosteroid injections?  
If no, why? \_\_\_\_\_  Yes  No
- j. Has the patient had a documented contraindication, or documented non-response, to all preferred products (Monovisc, Orthovisc, and a Synvisc product [either Synvisc or Synvisc-One])?  Yes  No
- k. Does the patient have an avian or egg allergy?  Yes  No

**3) For additional courses of treatment**

- a. Has the patient experienced significant improvement in pain and functional capacity of the joint(s) since the previous series of injections with this agent?  
If yes, on which date was the last injection of this agent given? \_\_\_\_\_  Yes  No
- b. Has the patient experienced significant reduction of other medications (e.g., NSAIDs) or a decreased number of intra-articular corticosteroid injections since the previous series of injections with this agent?  Yes  No

**4) Prescription information**

Quantity \_\_\_\_\_ refill x \_\_\_\_\_ month(s)  
 Instructions (include dose) \_\_\_\_\_ every \_\_\_\_\_ day(s)/ week(s)/ month(s)  
 Physician's signature \_\_\_\_\_

**Please fax this completed form to 215-761-9580.**