ATRIO HEALTH PLANS

Viscosupplements (Hyaluronan products)

Orthovisc J7324, Monovisc J7327 are non-preferred. The preferred products are Synvisc [One] J7325, Euflexxa J7323, Hyalgan/Supartz J7321 (Hyaluronate Sodium), Gel One J7326

No PA required for Preferred drugs.

Prior Authorization Step Therapy

Medicare Part B Request Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for clinical exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Viscosupplements Drugs PA

Drug Name(s):

EUFLEXXA	**MONOVISC**
ORTHOVISC	**SYNVISC**
HYALGAN	**SUPARTZ**
HYALURONIC ACID	**HYALURONIC SODIUM**

Criteria for approval of Non-Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE of the preferred alternatives: **Hyalgan, Euflexxa, Hyalgan/Supartz and Gel One** OR
   - There is clinical documentation stating preferred alternatives are contraindicated.
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Non-Preferred: Approval will be for 6 months
Preferred: No PA required.

FDA Indications:

Hyaluronic Sodium (all products):

- Cataract surgery; Adjunct
- Corneal transplant; Adjunct
- Filtering operation on eye; Adjunct
- Operative procedure on anterior chamber of eye; Adjunct
- Osteoarthritis of knee
- Retinal detachment repair; Adjunct
- Wound

Off-Label Uses:

Hyaluronic Sodium (all products):

- Arthropathy - Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

Step Therapy Drug(s) and FDA Indications:

See Above

Age Restrictions:

- Safety and effectiveness of intraocular injection in children have not been established
- safety and efficacy of intra-articular injection in pediatric patients have not been established, including patients younger than 21 years

Other Clinical Consideration:

Pre-existing hypocalcemia must be corrected prior to initiating therapy.

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/852E92/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/A9A3A8/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Hyaluronate%20Sodium&UserSearchTerm=Hyaluronate%20Sodium&SearchFilter=filterNone&navitem=searchGlobal#

https://careweb.careguidelines.com/ed24/ac/ac04_009.htm