BOSTON MEDICAL CENTER HEALTHNet PLAN

ENVISIONRx

PRIOR AUTHORIZATION REQUEST FORM

BMCHP 9.158 Viscosupplements
Euflexxa, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz, Synvisc, Synvisc-One
Version 12.0
Effective Date 1/1/18

Phone: 888-566-0008 **Fax back to: 866-741-8136**

EnvisonRx Options manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the request for initial or continuing therapy?
☐ Initial ☐ Continuing

Q2. For Continuing Therapy, please list the start date (MM/YY):

Q3. Which medication is being requested? *
☐ Euflexxa
☐ Other (Hyalgan, Gel-One, Gelsyn-3, Hymovis, Monovisc, Orthovisc, Supartz, Synvisc, Synvisc-One)

Q4. Please provide the diagnosis for which the medication is being requested:
☐ Osteoarthritis of the knee
☐ Other (please list)

Q5. If the diagnosis is OTHER, please list:

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Q6. Is the request for treatment of the right, left, or both knees?

☐ Right ☐ Left ☐ Both knees

Q7. Has the member had an inadequate response to conservative non-pharmacologic treatments such as education, strengthening and range of motion, assisted devices, and weight loss?

☐ Yes ☐ No

Q8. The patient must have an inadequate response to a 3 month trial of 3 different analgesics from 2 different classes. Please list the drugs and dates of trials.

☐ Medication 1:_____ Dates:_____
☐ Medication 2:_____ Dates:_____
☐ Medication 3:_____ Dates:_____
☐ Three drugs have not been tried

Q9. Has the patient had an inadequate response or intolerance to a trial of at least 2 courses of intraarticular corticosteroid injections over a period of 6 months, or repeated courses is clinically inappropriate. Please list the corticosteroid and the dates of use.

☐ Yes: Medication 1:_____ Dates:_____ and Medication 2:_____ Dates:_____
☐ No

Q10. Has there been an inadequate response or intolerance to a complete treatment cycle with Euflexxa? If yes, please describe the inadequate response or intolerance to treatment below:

☐ Yes (please specify) ☐ No

Q11. For REAUTHORIZATION: Have six months elapsed from the end of the last treatment cycle? Please specify the date of the previous treatment.

☐ Yes ☐ No

Q12. For REAUTHORIZATION, Has there been significant improvement in pain and functional status as a result of viscosupplementation. (attach chart notes).

☐ Yes ☐ No

Q13. If coverage of medication is approved, how will this medication be supplied? (Please check one)

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Patient Name: **Prescriber Name:**

- ☐ Order through Plan Preferred Specialty Pharmacy
- ☐ Provider/Hospital Buy & Bill

Q14. If Buy and Bill, please provide the following information:

- ☐ J-codes:_____
- ☐ Procedure code(s) for administration of medication:_____
- ☐ Number of Units and Visits:_____
- ☐ Date of planned administration:_____

_____ _____

Prescriber Signature Date