Hyaluronates

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name:_____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit, CVS Caremark Specialty Programs Fax: 1-855-330-1720

 CareFirst MR C26690-A, Hyaluronates SGM 1765-A – 4/2026.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Exception Criteria Questions:

A. Is the product being requested for a patient with osteoarthritis of the knee?
❒ Yes, *Continue to Question B*
❒ No, *Skip to Criteria Questions*

B. What is the requested product?
❒ Durolane, *Skip to Clinical Criteria Questions*
❒ Euflexxa, *Skip to Clinical Criteria Questions*
❒ Gel-one, *Continue to Question C*
❒ Gelsyn-3, *Skip to Clinical Criteria Questions*
❒ Genvisc 850, *Continue to Question C*
❒ Hyalgan, *Continue to Question C*
❒ Hymovis One, *Continue to Question C*
❒ Monovisc, *Continue to Question C*
❒ Orthovisc, *Continue to Question C*
❒ Supartz fx, *Continue to Question C*
❒ SynoJoynt, *Continue to Question C*
❒ Synvisc, *Continue to Question C*
❒ Synvisc-One, *Continue to Question C*
❒ Triluron, *Continue to Question C*
❒ Trivisc, *Continue to Question C*
❒ Visco-3, *Continue to Question C*

C. The preferred products for your patient's health plan are Durolane, Euflexxa, and Gelsyn-3.
Can the patient's treatment be switched to one of the preferred products?
❒ Yes, *Skip to Clinical Criteria Questions*
❒ No, *Continue to Question D*

D. Is there documentation that the patient is currently undergoing treatment and coverage is required to complete the current course of treatment (i.e., patient requires additional injection(s) to complete the current treatment course for the affected joint)? ***Action Required***: If 'Yes', attach supporting chart note(s).
❒ Yes, please specify dates of injection(s) and affected joint. *Skip to Criteria Questions*
i) Date of Injection: _____ i) Affected Joint: _____
ii) Date of Injection: _____ ii) Affected Joint: _____
iii) Date of Injection: _____ iii) Affected Joint: _____
iv) Date of Injection: _____ iv) Affected Joint: _____

❒ No, *Continue to Question E*

E. Did the patient have a documented inadequate response, intolerable adverse event, or contraindication to all preferred products (Durolane, Euflexxa, and Gelsyn-3)? ***Action Required***: If 'Yes', attach supporting chart note(s)
❒ Yes, *Continue to Criteria Questions*
❒ No, *Continue to Criteria Questions*

Clinical Criteria Questions:

1. What is the prescribed medication?

❒ Durolane, *Continue to 2*
❒ Euflexxa, *Continue to 2*
❒ Gel-One, *Continue to 2*
❒ Gelsyn-3, *Continue to 2*
❒ GenVisc 850, *Continue to 2*
❒ Hyalgan, *Continue to 2*
❒ Hymovis, *Continue to 2*
❒ Hymovis One, *Continue to 2*
❒ Monovisc, *Continue to 2*
❒ Orthovisc, *Continue to 2*
❒ Supartz FX, *Continue to 2*
❒ Synojoynt, *Continue to 2*
❒ Synvisc, *Continue to 2*
❒ Synvisc One, *Continue to 2*
❒ TriVisc, *Continue to 2*
❒ Triluron, *Continue to 2*
❒ Visco-3, *Continue to 2*

2. What is the diagnosis?

❒ Osteoarthritis of the knee, *Continue to 3*
❒ Other, please specify. _____, *Continue to 3*

3. Is the diagnosis supported by radiographic evidence of osteoarthritis of the knee, such as joint space narrowing, subchondral sclerosis, osteophytes, and sub-chondral cysts?

❒ Yes, *Continue to 5*
❒ No, *Continue to 4*

4. At the time of diagnosis, did/does the patient have at least 5 of the following signs and symptoms: A) Bony enlargement, B) Bony tenderness, C) Crepitus (noisy, grating sound) on active motion, D) Erythrocyte sedimentation rate (ESR) less than 40 mm per hour, E) Less than 30 minutes of morning stiffness, F) No palpable warmth of synovium, G) Over 50 years of age, H) Rheumatoid factor less than 1:40 titer (agglutination method), or I) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm^3)?

❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Does the patient have knee pain which interferes with functional activities (e.g., ambulation, prolonged standing)?

❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Has the patient experienced an inadequate response or adverse effects with non-pharmacologic treatment options (e.g., physical therapy, regular exercise, insoles, knee bracing, weight reduction)?

❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Has the patient experienced an inadequate response or intolerance to a trial of an analgesic (e.g., acetaminophen up to 3 to 4 grams per day, non-steroidal anti-inflammatory drugs [NSAIDs], topical capsaicin cream) for at least 3 months?

❒ Yes, *Continue to 9*
❒ No, *Continue to 8*

8. Does the patient have a contraindication to a trial of an analgesic (e.g., acetaminophen up to 3 to 4 grams per day, non-steroidal anti-inflammatory drugs [NSAIDs], topical capsaicin cream) for at least 3 months?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Has the patient experienced an inadequate response or intolerance to a trial of intraarticular steroid injections for at least 3 months?
❒ Yes, *Continue to 11*
❒ No, *Continue to 10*

10. Does the patient have a contraindication to a trial of intraarticular steroid injections for at least 3 months?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the patient scheduled to undergo a total knee replacement within 6 months of starting treatment?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Please indicate if this request is for initiation of therapy (first time use), continuation of therapy (in the middle of a treatment series), or re-start of therapy (the patient has been treated with viscosupplementation in the past).
❒ Initiation of therapy (first time use), *No further questions*
❒ Continuation of therapy (the patient is in the middle of therapy), *No further questions*
❒ Re-start of therapy (the patient has received viscosupplementation in the past), *Continue to 13*

13. Has the patient experienced improvement in pain and functional capacity following the previous injections?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Was the previous series of injections completed at least 6 months prior to this request?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Step Therapy Override 2197-D: Complete if Applicable for the state of Maryland.	Please Circle	
1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
3. Is the alternate drug FDA-approved for the medical condition being treated? *If No, No Further Questions*	Yes	No
4. Has the prescriber documented in the patient's chart that the requested drug was ordered for the patient in the past 180 days? *If No, Skip to 6*	Yes	No
5. Has the prescriber documented in the patient's chart that in their opinion the requested drug is effective for the patient's condition? *If Yes or No*, *No Further Questions*	Yes	No
6. Is the alternate drug contraindicated or will likely cause an adverse reaction to the patient? *If Yes, No Further Questions*	Yes	No
7. Is the alternate drug expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen? *If Yes, No Further Questions*	Yes	No
8. Is the patient stable on the requested drug for the medical condition under consideration? *If Yes, No Further Questions*	Yes	No
9. Has the patient tried a prescription drug while covered under their current policy or a previous source of coverage, that is in the same pharmacologic class or has the same mechanism of action as the alternate drug and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? *No Further Questions*	Yes	No

Step Therapy Override 3145-D: Complete if Applicable for the state of Virginia.	Please Circle	
1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
3. Is the alternate drug contraindicated? *If Yes, No Further Questions*	Yes	No
4. Is the alternate drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen? *If Yes, No Further Questions*	Yes	No
5. Has the patient tried the alternate drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? NOTE: Pharmaceutical drug samples are not considered trial and failure of a preferred drug. *If Yes, No Further Questions*	Yes	No
6. Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition? *No Further Questions*	Yes	No

I attest *that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.*

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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