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 – 01/2025.

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 C*

❒ No, *Skip to Criteria Questions*

B. What is the requested product?

❒ Durolane, *No Further Questions*

❒ Euflexxa, *No Further Questions*

❒ Gel-one, *Continue to Question C*

❒ Gelsyn-3, *No Further Questions*

❒ Genvisc 850, *Continue to Question C*

❒ Hyalgan, *Continue to Question C*

❒ Hymovis, *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 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 both 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*

Criteria Questions:

1. What is the prescribed medication?

❒ Gel-One, *Continue to 2*

❒ Gelsyn-3, *Continue to 2*

❒ Supartz FX, *Continue to 2*

❒ Visco-3, *Continue to 2*

❒ Durolane, *Continue to 2*

❒ Euflexxa, *Continue to 2*

❒ GenVisc 850, *Continue to 2*

❒ Hyalgan, *Continue to 2*

❒ Hymovis, *Continue to 2*

❒ Monovisc, *Continue to 2*

❒ Orthovisc, *Continue to 2*

❒ Synojoynt, *Continue to 2*

❒ Synvisc, *Continue to 2*

❒ Synvisc One, *Continue to 2*

❒ TriVisc, *Continue to 2*

❒ Triluron, *Continue to 2*

❒ 1% sodium hyaluronate, *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/mm3)?

❒ 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: Complete if Applicable for the state of Maryland.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
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
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
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred 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?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition?	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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