BlueCross BlueShield Federal Employee Program

HYALURONIC ACID DERIVATIVES PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients Gel-ONE, GelSyn-3, Hyalgan, and Supartz are preferred products. Please consider prescribing a preferred product. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑Durolane	**❑GenVisc 850**	**❑Orthovisc**	**❑Synvisc-One**	**❑Visco-3**
❑Euflexxa	**❑Hyalgan**	**❑Sodium Hyaluronate**	**❑Supartz**	
❑Gel-ONE	**❑Hymovis**	**❑Synojoynt**	**❑Triluron**	
❑GelSyn-3	**❑Monovisc**	**❑Synvisc**	**❑TriVisc**	

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. **Non-Preferred Product Request (Standard/Basic Option), for claims adjudicated through the pharmacy benefit**: Would you like to participate in this program and switch the patient to GelSyn-3, Hyalgan, Supartz, or Gel-ONE? ***Please select the answer below:***
   ❑**Yes** ***(please select the preferred product)***: ❒Gel-ONE ❒GelSyn-3 ❒Hyalgan ❒Supartz
   ❑**No:** Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **TWO** preferred products? ❑Yes ❑No***
   ****If NO,*** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

2. **Preferred Product Request (Standard/Basic Option), for claims adjudicated through the pharmacy benefit:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Durolane, Euflexxa, GenVisc, Sodium Hyaluronate, Synojoynt, Triluron, TriVisc, Visco-3, Hymovis, Monovisc, Orthovisc, Synvisc, or Synvisc-One? ❑Yes* ❑No
   ****If YES***, please select medication: ❑Durolane ❑Euflexxa ❑GenVisc ❑Hymovis ❑Monovisc ❑Orthovisc ❑Sodium Hyaluronate ❑Synojoynt ❑Synvisc ❑Synvisc-One ❑TriVisc ❑Triluron ❑Visco-3

3. Will the injections be used to treat osteoarthritis of the knee? ❑Yes ❑No

4. Please specify the knee(s) being treated: ❑Left knee only ❑Right knee only ❑Both knees

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

5. Is this **INITIATION** or **CONTINUATION** of therapy with a hyaluronic acid agent? ***Please select answer below:***
   If INITIATION is for one knee and CONTINUATION is for the other knee, please complete both Initiation and Continuation.

❑ **INITIATION** of therapy, please answer the following questions:

a. Has the patient failed to achieve an adequate response to **TWO** or more of the following: resistance exercise, weight reduction (for persons who are overweight), participation in self-management programs, wearing of medially directed patellar taping, wearing of wedged insoles, thermal agents, walking aids, physical therapy, occupational therapy, or cardiovascular (aerobic) activity, such as walking, biking, stationary bike, or aquatic exercise? ❑Yes ❑No

❑Other therapy/therapies not listed ***(please specify)***: _____

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to intra-articular steroid injections in which efficacy lasted less than 8 weeks? ❑Yes ❑No

c. Does the patient have radiologic confirmation of a Kellgren-Lawrence Scale score of grade 2 or greater? ❑Yes ❑No

d. Does the patient have an intolerance or contraindication or have they had inadequate treatment response to **TWO** or more of the following: Acetaminophen (Tylenol), oral NSAIDs, or topical NSAIDs? ❑Yes ❑No

❑Other treatment not listed ***(please specify)***: _____

❑ **CONTINUATION (PA renewal)** of therapy, please answer the following questions:

a. Has there been a documented improvement in pain with the previous course of treatment? ❑Yes ❑No

b. Has there been a documented reduction of dosing NSAIDs or other analgesic during the 12-month period following the last injection of the prior treatment cycle? ❑Yes ❑No

c. Have at least 12 months elapsed since the last injection of the prior treatment cycle? ❑Yes ❑No