FirstCare HEALTH PLANS

Preferred Viscosupplements
Medical Benefit Prior Authorization

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Member First & Last Name:	Prescriber NPI:
Member Address:	Prescriber Address:
Member ID:	Prescriber Phone:
Member Birth Date:	Prescriber Fax:

STEP 2: INDICATE MEDICATION REQUESTED	
☐ DUROLANE **(C9465)** ☐ 1 dosage series (equal to 1 injection) per knee in 180 days	☐ GELSYN-3 **(J7328)** ☐ 1 dosage series (equal to 3 injections) per knee in 180 days
☐ SUPARTZ FX **(J7321)** ☐ 1 dosage series (equal to 5 injections) per knee in 180 days	☐ SYNVISC **(J7325)** ☐ 1 dosage series (equal to 3 injections) per knee in 180 days
☐ SYNVISC-ONE **(J7325)** ☐ 1 dosage series (equal to 1 injection) per knee in 180 days	☐ Other: _____

STEP 3: REQUESTED DRUG INFORMATION

Strength/Dosage and Dosing Frequency:
If the prescriber would like a different strength, dosage and/or dosing frequency than listed above, please provide medical rational for exception: _____

_____

Location of Administration

☐ Home **(POS: 12)**
☐ Clinic/Office **(POS: 11)**
☐ Outpatient Treatment Center **(POS: 22)**
☐ Other: _____

Name of Facility: _____

Address: _____ Phone Number: _____

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STEP 4: COMPLETE REQUIRED CRITERIA

ICD 10 Code: ☐ M17.1 ☐ Other: _____

INITIAL THERAPY:

☐ Prescribed for a confirmed diagnosis of symptomatic osteoarthritis of the knee

AND ☐ Member has **five (5)** documented symptomatic osteoarthritis of the knee according to the American College of Rheumatology (ACR) clinical and laboratory criteria listed below:

- ☐ Bony Enlargement
- ☐ Bony Tenderness
- ☐ Crepitus on active motion
- ☐ Erythrocyte sedimentation rate less than 40 mm/hr
- ☐ Less than 30 minutes of morning stiffness
- ☐ No palpable warmth of synovium
- ☐ Over 50 years of age
- ☐ Rheumatoid factor less than 1:40 titer
- ☐ Synovial fluid signs (clear fluid of normal viscosity and white blood cell count is less than 2000/mm3

AND ☐ Therapy is limited to the knee

AND ☐ Member has had an inadequate response to **both** of the following after a trial of 3 months:

- ☐ Non-pharmacologic therapy- including education, strength training, range of motion exercises, assisted devices and weight loss
- **AND** ☐ Analgesic therapy including acetaminophen, non-steroidal anti-inflammatory drugs, topical capsaicin or salicylates

AND ☐ Member had a prior trial or contraindication to intra-articular corticosteroid therapy

AND ☐ Member is not scheduled to undergo a total knee replacement within 6 months of treatment

AND ☐ Member has no contraindications to therapy

CONTINUING THERAPY:

☐ Six months have elapsed since the prior treatment cycle

AND ☐ Documentation of significant improvement in pain and function resulting from prior intra-articular HA therapy **[documentation required]**

AND ☐ Member is not scheduled to undergo a total knee replacement within 6 months of treatment

AND ☐ Member has no contraindications to therapy

STEP 5: SIGN AND FAX TO: PRIOR AUTHORIZATION: 800-248-1852

Prescriber Signature: _____ **Date:** _____

If member meets criteria, allow 2 business days for processing.

If criteria not met, submit chart documentation with form citing complex medical circumstance.

If approved, coverage allowed for 1 dosage series per knee in 180 days (subject to formulary changes).

For Questions, please call FirstCare Health Plans Customer Service 1-800-884-4905 or www.firstcare.com