Osteoarthritis

Prior Authorization Request

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

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 **1-866-814-5506.** 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:** _____

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

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

1. What is the ICD-10 code? _____

2. What drug is being prescribed?
   Preferred Products - Indicate and no further questions:
   - ❑ Hyalgan
   - ❑ Hymovis
   - ❑ Synvisc
   - ❑ Synvisc One

   Non-Preferred Products:

❑ Euflexxa	❑ Gel-one	❑ Gelsyn-3
❑ GenVisc 850	❑ Monovisc	❑ Orthovisc
❑ Supartz FX	❑ Other _____	

2. The preferred hyaluronate products for your patient's plan are Hyalgan (sodium hyaluronate), Hymovis (high molecular weight viscoelastic hyaluronan), Synvisc (hylan G-F 20) and Synvisc One (hylan G-F 20). Can the patient's treatment be switched to one of the preferred products?
   - ❑ Yes – Hyalgan, *no further questions*
   - ❑ Yes – Hymovis, *no further questions*
   - ❑ Yes – Synvisc, *no further questions*
   - ❑ Yes – Synvisc One, *no further questions*
   - ❑ No

3. Is the patient in the middle of a treatment course (i.e., patient requires additional injection(s) to complete the current treatment course for the affected joint)? ❑ Yes ❑ No

   Number of injections per treatment course

   - Euflexxa: 3 injections (2 mL each; 6 mL total) per course
   - Gelsyn-3: 3 injections (2 mL each, 6 mL total) per course
   - GenVisc 850: 3 to 5 injections (2.5 mL each; 12.5 mL total)
   - Orthovisc: 3 or 4 injections (2 mL each; 8 mL total) per course
   - Supartz FX: 3 to 5 injections (2.5 mL each; 12.5 mL total) per course

   If Yes, indicate dates of injection and affected joint

   A) Date of Injection: _____ B) Affected Joint: _____
   B) Date of Injection: _____ B) Affected Joint: _____
   C) Date of Injection: _____ B) Affected Joint: _____
   D) Date of Injection: _____ B) Affected Joint: _____

4. Has the patient tried and experienced an intolerable adverse event to Hyalgan, Hymovis, and Synvisc or Synvisc One? ❑ Yes ❑ No

5. What is the diagnosis?
   ❑ Osteoarthritis of the knee
   ❑ Osteoarthritis of the hip
   ❑ Osteoarthritis of the shoulder
   ❑ Other _____

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)**