

**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.

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

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

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Inpatient Hospital Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

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:

- | | | |
|--------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Euflexxa | <input type="checkbox"/> Gel-one | <input type="checkbox"/> Gelsyn-3 |
| <input type="checkbox"/> GenVisc 850 | <input type="checkbox"/> Monovisc | <input type="checkbox"/> Orthovisc |
| <input type="checkbox"/> Supartz FX | <input type="checkbox"/> Visco-3 | <input type="checkbox"/> Other _____ |

3. 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*

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Yes – Synvisc One, *no further questions*

No

4. 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)?

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

Yes – *Indicate dates and affected joints below and skip to Question 6.*

No

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: _____

5. Has the patient experienced a documented intolerable adverse event to Hyalgan, Hymovis, and Synvisc or Synvisc One? **Action Required:** *If 'Yes', please attach supporting chart note(s).* Yes No

6. 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)