Osteoarthritis

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

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*

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

 Osteoarthritis CareFirst – 07/2021.

Exception Criteria Questions:

A. What drug is being prescribed?

Preferred Products - Indicate and no further questions:

❑ Orthovisc
❑ Synvisc
❑ Synvisc One

Other Products:

❑ Euflexxa	❑ Gel-one	❑ Gelsyn-3	❑ Hyalgan
❑ GenVisc 850	❑ Monovisc	❑ Hymovis	❑ Durolane
❑ Supartz FX	❑ Visco-3	❑ Trivisc	
❑ Triluon *Skip to Criteria Questions*		❑ Other _____	

B. Is the product being requested for the treatment of osteoarthritis of the knee?
❑ Yes ❑ No, *skip to criteria questions*

C. The preferred hyaluronate products for your patient's plan are Orthovisc, Synvisc, and Synvisc One. Can the patient's treatment be switched to one of the preferred products?
❑ Yes – Orthovisc, *no further questions*
❑ Yes – Synvisc, *no further questions*
❑ Yes – Synvisc One, *no further questions*
❑ No

D. Is the request for Durolane, Gel-One or Monovisc? ❑ Yes, *If Yes, skip to #6* ❑ No

E. 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) per course
- Hyalgan: 3 to 5 injections (2 mL each; 10 mL total) per course
- Hymovis: 2 injections (3 mL each; 6 mL total) per course
- Supartz FX: 3 to 5 injections (2.5 mL each; 12.5 mL total) per course
- Trivisc: 3 injections (3ml each, 9 ml total) per course
- Visco-3: 3 injections (2.5ml each, 7.5ml total) per course

❑ Yes – *Indicate dates and affected joints below and skip to criteria questions*
❑ 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: _____

F. Has the patient experienced a documented intolerable adverse event to at least two of the preferred products: A) Orthovisc and B) Synvisc or Synvisc One? ***Action Required***: ***If 'Yes', please attach supporting chart note(s).***
❑ Yes ❑ No

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Criteria Questions:

1. What drug is being prescribed?
   - ❑ Euflexxa
   - ❑ Gel-One
   - ❑ Gelsyn-3
   - ❑ Hymovis
   - ❑ Hyalgan
   - ❑ GenVisc 850
   - ❑ Monovisc
   - ❑ Orthovisc
   - ❑ Supartz FX
   - ❑ Synvisc
   - ❑ Synvisc One
   - ❑ Triluron
   - ❑ Durolane
   - ❑ sodium hyaluronate
   - ❑ Trivisc
   - ❑ Visco-3
   - ❑ Other _____

2. What is the diagnosis? ❑ Osteoarthritis of the knee ❑ Other _____

3. What is the ICD-10 code? _____

4. Is the diagnosis supported by radiographic evidence of osteoarthritis of the knee, such as joint space narrowing, subchondral sclerosis, osteophytes, and sub-chondral cysts? *If Yes, skip to #6* ❑ Yes ❑ No

5. At the time of diagnosis, did/does the patient have ANY of the following signs and symptoms?
   Indicate ALL that apply.
   - ❑ Bony enlargement
   - ❑ Bony tenderness
   - ❑ Crepitus (noisy, grating sound) on active motion
   - ❑ Less than 30 minutes of morning stiffness
   - ❑ No palpable warmth of synovium
   - ❑ Over 50 years of age
   - ❑ Erythrocyte sedimentation rate (ESR) less than 40 mm/hr
   - ❑ Rheumatoid factor less than 1:40 titer (agglutination method)
   - ❑ Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3)
   - ❑ None of the above

6. Does the patient have knee pain which interferes with functional activities (e.g., ambulation, prolonged standing)? ❑ Yes ❑ No

7. 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 ❑ No

8. 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? *If Yes, skip to #10* ❑ Yes ❑ No

9. 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 ❑ No

10. Has the patient experienced an inadequate response or intolerance to a trial of intraarticular steroid injections for at least 3 months? *If Yes, skip to #12* ❑ Yes ❑ No

11. Does the patient have a contraindication to a trial of intraarticular steroid injections for at least 3 months? ❑ Yes ❑ No

12. Is the patient scheduled to undergo a total knee replacement within 6 months of starting treatment? ❑ Yes ❑ No

13. 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 a 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 a viscosupplementation in the past)

14. Has the patient experienced improvement in pain and functional capacity following the previous injections? ❑ Yes ❑ No

15. Was the previous series of injections completed at least 6 months prior to this request? ❑ Yes ❑ No

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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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