POLICY Document for Hyaluronates

The overall objective of this policy is to support the appropriate and cost effective use of the medication, specific to use of preferred medication options, and overall clinically appropriate use. This document provides specific information to both sections of the overall policy.

Section 1: Preferred Product

- Policy information specific to preferred medications

Section 2: Clinical Criteria

- Policy information specific to the clinical appropriateness for the medication

Section 1: Preferred Product

EXCEPTIONS CRITERIA

HYALURONATES

PREFERRED PRODUCTS: HYALGAN, HYMOVIS, SYNVISC AND SYNVISC ONE

POLICY

This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

I. PLAN DESIGN SUMMARY

This program applies to the hyaluronate products specified in this policy. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to members who are initiating a new treatment course with a targeted product. Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Hyaluronate products

	Products
Preferred	• **Hyalgan** (sodium hyaluronate) • **Hymovis** (high molecular weight viscoelastic hyaluronan) • **Synvisc** (hylan G-F 20) • **Synvisc One** (hylan G-F 20)
Targeted	• **Durolane** (hyaluronic acid) • **Euflexxa** (1% sodium hyaluronate) • **Gel-One** (cross-linked hyaluronate) • **Gelsyn-3** (sodium hyaluronate) • **Genvisc 850** (sodium hyaluronate) • **Monovisc** (high molecular weight hyaluronan) • **Orthovisc** (high molecular weight hyaluronan)

	• **Supartz FX** (sodium hyaluronate) • **Visco-3** (sodium hyaluronate)

II. EXCEPTION CRITERIA

Coverage for a targeted product is provided when either of the following criteria is met:

A. Member is currently undergoing treatment and coverage is required to complete the current course of treatment.

Number of injections per treatment course

- Durolane: 1 injection (3 mL each, 3 mL total) per course
- Euflexxa: 3 injections (2 mL each; 6 mL total) per course
- Gel-One: 1 injection (3 mL each; 3 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)
- Monovisc: 1 injection (4 mL each, 4 mL total) per course
- 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 courseVisco-3 (sodium hyaluronate): 3 injections (2.5 mL each, 7.5 mL total) per course

B. Member has tried and experienced a documented intolerable adverse event to all of the preferred products.

Section 2: Clinical Criteria

HYALURONATES

DUROLANE (hyaluronic acid)
EUFLEXXA (1% sodium hyaluronate)
GEL-ONE (cross-linked hyaluronate)
GELSYN-3 (sodium hyaluronate 0.84%)
GENVISC 850 (sodium hyaluronate)
HYALGAN (sodium hyaluronate)
HYMOVIS (high molecular weight viscoelastic hyaluronan)
MONOVISC (high molecular weight hyaluronan)
ORTHOVISC (high molecular weight hyaluronan)
SUPARTZ (sodium hyaluronate)
SYNVISC (hylan G-F 20)
SYNVISC ONE (hylan G-F 20)
VISCO-3 (sodium hyaluronate)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication
Treatment of pain in osteoarthritis of the knee in patients who have failed to respond adequately to conservative non-pharmacologic therapy and simple analgesics (e.g., acetaminophen)

B. Compendial Uses
1. Treatment of pain in osteoarthritis of the shoulder
2. Treatment of pain in osteoarthritis of the hip

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Osteoarthritis (OA) of the Knee, Hip, or Shoulder
Authorization of 12 months may be granted for treatment of osteoarthritis (OA) in the knee, hip or shoulder.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

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SECTION 2

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