CareFirst Family of health care plans

CVS caremark™

Osteoarthritis (for Maryland only)

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.

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. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ACTION REQUIRED: ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*

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6. 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: ______________________

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

8. What is the patient's diagnosis?

   ❑ Osteoarthritis of the knee (left)
   ❑ Osteoarthritis of the knee (right)
   ❑ Osteoarthritis of the knees (both)
   ❑ Osteoarthritis of the hip
   ❑ Osteoarthritis of the shoulder (left)
   ❑ Osteoarthritis of the shoulder (right)
   ❑ Osteoarthritis of the shoulders (both)
   ❑ Other ____

9. Has the patient had an inadequate response to non-drug therapies (eg, exercise, weight loss if applicable, physical therapy, walking aids, insoles)? ❑ Yes ❑ No

10. Has the patient had a inadequate response to any of the following drug therapies?
    Indicate below or mark "None of the above"

    ❑ Acetaminophen
    Specify drug: ❑ Tylenol ❑ Other _________________________

    ❑ Nonsteroidal anti-inflammatory drug (NSAID)
    Specify drug(s): ❑ Ibuprofen (Advil, Motrin) ❑ Naproxen (Aleve, EC Naprosyn, Naprelan) ❑ Piroxicam (Feldene) ❑ Nabumetone (Relafen) ❑ Indomethacin (Indocin) ❑ Ketoprofen ❑ Meloxicam (Mobic) ❑ Oxaprozin (Daypro) ❑ Diflunisal ❑ Etodolac (Lodine) ❑ Flurbiprofen (Ansaid) ❑ Salsalate ❑ Diclofenac (Cataflam, Voltaren, Arthrotec) ❑ Other _________________________

    ❑ Cyclooxygenase-2 (COX2) inhibitor
    Specify drug: ❑ Celecoxib (Celebrex) ❑ Other _________________________

    ❑ Tramadol (Ultram)

    ❑ Intra-articular corticosteroid injection
    Specify drug: ❑ Depo-Medrol, Kenalog ❑ Other _________________________

    ❑ None of the above

11. What is the affected joint?
    ❑ Knee, *skip to #13* ❑ Hip ❑ Shoulder (glenohumeral joint) ❑ Other _______________________________

12. Will the injection be administered using an image-guided method (eg, fluoroscopy, ultrasound, or computed tomography)? ❑ Yes ❑ No

13. Has the patient previously received a treatment with any intra-articular hyaluronate product?
    ❑ Yes ❑ No *If No, no further questions.*

    A) Previous course of therapy:
    ❑ Euflexxa ❑ Gel-One ❑ Gelsyn-3 ❑ GenVisc 850 ❑ Hyalgan ❑ Hymovis
    ❑ Monovisc ❑ Orthovisc ❑ Supartz ❑ Synvisc ❑ Synvisc One

    B) Specify previous joint: ❑ Left knee ❑ Left hip ❑ Left shoulder (glenohumeral joint)
    ❑ Right knee ❑ Right hip ❑ Right shoulder (glenohumeral joint)
    ❑ Other _______________________________

    C) Date of the FIRST injection of the last course of treatment: ________________

Date of the LAST injection: ________________

Date of NEXT planned injection: ________________

D) Adverse reaction(s): ____

14. Is the next injection with the requested product planned at least 6 months after the first injection of the last course of treatment with any intra-articular hyaluronate product? *If Yes, skip to #17* ❑ Yes ❑ No
15. Does the patient meet the following criteria? ***Indicate all that apply or mark "None of the above"***
    If patient meets both of the following, skip to #17.
    ❑ The request is for the treatment of a different joint
    ❑ The next injection is planned at least 6 months after the first injection of the last course of treatment with any intra-articular hyaluronate product for this joint
    ❑ None of the above
16. Does the patient meet the following criteria?
    Indicate all that apply or mark "None of the above" and no further questions.
    ❑ The patient experienced an adverse reaction to the hyaluronate product used for the previous treatment
    ❑ The requested product is different from the one used for the previous treatment
    ❑ None of the above
17. Is the request for continuation of therapy with the same product? ❑ Yes ❑ No *If No, no further questions.*
18. Has the patient received a full course of treatment with the requested product for the same joint?
    ❑ Yes ❑ No *If No, no further questions.*
    Course of therapy for intra-articular hyaluronate products
    - Euflexxa: 3 injections (2 mL each; 6 mL total)
    - Gel-One: 1 injection (3 mL each; 3 mL total)
    - Gelsyn-3: 3 injections (2 mL each, 6 mL total)
    - GenVisc 850: 3 to 5 injections (2.5 mL each; 12.5 mL total)
    - Hyalgan: 3 to 5 injections (2 mL each; 10 mL total)
    - Hymovis: 2 injections (3 mL each, 6 mL total)
    - Monovisc: 1 injection (4 mL each, 4 mL total)
    - Orthovisc: 3 or 4 injections (2 mL each; 8 mL total)
    - Supartz: 3 to 5 injections (2.5 mL each; 12.5 mL total)
    - Synvisc One: 1 injection (6 mL each; 6 mL total)
    - Synvisc: 3 injections (2 mL each; 6 mL total)
19. Did the patient experience pain relief from this previous course of therapy? ❑ 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)**