

**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

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"/> 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

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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)