Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

Hyaluronic Acid Derivatives
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information							
Preferred Agents:	☐ **Gel-One**		☐ **Hyalgan**				
Medication request is NOT for an FDA approved, or compendia supported diagnosis (circle one): ☐Yes ☐No	ICD-10 Code:		Diagnosis:				
What medication(s) have been tried and failed for diagnosis?							
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request			
For continuation of therapy request ONLY:	Have SIX months elapsed since previous treatment?	☐ Yes	☐ No	☐ Is there documentation to support improved response to previous series? (for example, dose reduction with NSAIDs OR other analgesics)	☐ Yes	☐ No	
Directions for Use:	Strength:		Dosage Form:				
	Quantity:	Day Supply:	Duration of Therapy/Use:				

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information							
Was there inadequate response, intolerable side effect, or contraindication to non-pharmacologic therapy (for example, physical therapy, land based or aquatic based exercise, resistance training, or weight loss)?					☐ Yes	☐ No	
Was there inadequate response, intolerable side effect, or contraindication to trial of pharmacologic therapy, one of which must be oral or topical NSAIDs?					☐ Yes	☐ No	
Was there inadequate response, intolerable side effect, or contraindication to intra-articular steroid injections?					☐ Yes	☐ No	
Does the pain interfere with functional activities (for example, ambulation, or prolonged standing?	☐ Yes	☐ No	Is the pain attributed to other forms of joint disease?		☐ Yes	☐ No	
Did member have surgery on the same knee in the past 6 months?					☐ Yes	☐ No	
Treatment request is due to any of the following	☐ Temporomandibular joint disorders						

indications?	☐ Chondromalacia of patella (chondromalacia patellae)		
	☐ Pain in joint, lower leg (patellofemoral syndrome)		
	☐ Osteoarthrosis and allied disorders (joints other than knee)		
	☐ Diagnosis of osteoarthritis of hip, hand, shoulder, etc.		
Does member have documentation of radiographic evidence of mild to moderate osteoarthritis of knee? (for example, severe joint space narrowing, subchondral sclerosis, osteophytes)		☐ Yes	☐ No
☐ Member has documentation of symptomatic OA of knee according to ACR clinical AND laboratory criteria, which requires knee pain AND at least FIVE of the following?	☐ Bony enlargement		
	☐ Bony tenderness		
	☐ Crepitus (noisy, grating sound) on active motion		
	☐ ESR <40 mm/hour		
	☐ < 30 minutes of morning stiffness		
	☐ No palpable warmth of synovium		
	☐ Rheumatoid factor <1:40 titer (agglutination method)		
	☐ Synovial fluid signs (clear fluid of normal viscosity AND white blood cells <2000/mm3)		

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.