aetna®

MEDICARE FORM
Viscosupplementation Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

For Virginia HMO SNP:
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

For other lines of business:
Please use other form.

Note: Durolane, Euflexxa, Gelsyn-3, GenVisc, Hyalgan, Hymovis, Monovisc, Supartz, and TriVisc are non-preferred. The preferred products are Gel-One, Orthovisc, Synvisc, Synvisc One, and Visco-3.

Please indicate: ☐ Start of treatment: Start date ____/____/____ ☐ Continuation of therapy (Request Additional Series Below)

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:	City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:	Phone:				

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ Euflexxa (1% sodium hyaluronate) ☐ Durolane (hyaluronic acid) ☐ Gel-One (cross-linked hyaluronate)
☐ Gelsyn-3 (sodium hyaluronate) ☐ GenVisc 850 (sodium hyaluronate) ☐ Hyalgan (sodium hyaluronate) ☐ Supartz FX (sodium hyaluronate)
☐ Hymovis (high molecular weight viscoelastic hyaluronan) ☐ Orthovisc (high molecular weight hyaluronan) ☐ Monovisc (sodium hyaluronate)
☐ Synvisc (hylan G-F 20) ☐ Synvisc-One (hylan G-F 20) ☐ TriVisc (sodium hyaluronate) ☐ Visco-3 (sodium hyaluronate)
☐ Synojoynt (1% sodium hyaluronate) ☐ Triluron (1% sodium hyaluronate)

Dose: _____ **Frequency:** _____ **HCPCS Code:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (includes Medicare patient requests, clinical documentation required for all requests):

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☐ Yes ☐ No Has the patient had prior therapy with the requested viscosupplementation product within the last 365 days?
☐ Yes ☐ No Has the patient had an intolerance or contraindication to Gel-One, Orthovisc, Synvisc, Synvisc One, or Visco-3?
Please explain if there are any other medical reason(s) that the patient cannot use Gel-One, Orthovisc, Synvisc, Synvisc One, or Visco-3

_____

_____

☐ Yes ☐ No Does the patient have documented symptomatic osteoarthritis (OA) of the tibiofemoral articulation of the knee?
→ Which knee will the viscosupplement be used? ☐ Left knee ☐ Right knee ☐ Both knees

Continued on next page

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Is there radiologic evidence of osteoarthritis (OA) of the knee?
- ☐ Yes ☐ No Is the patient symptomatic?
  - Which of the following documented symptoms of osteoarthritis (OA) does the patient have? (Check ALL that apply)
    ☐ Knee Pain ☐ Bony enlargement ☐ Bony tenderness ☐ Crepitus (noisy, grating sound) on active motion
    ☐ Erythrocyte sedimentation rate (ESR) less than 40 mm/hr ☐ Less than 30 minutes of morning stiffness
    ☐ No palpable warmth of synovium ☐ Over 50 years of age
    ☐ Rheumatoid factor less than 1:40 titer (agglutination method)
    ☐ Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3)
- Which of the following radiologic findings support the clinical diagnosis of osteoarthritis (OA)?
  Please select: ☐ Joint space narrowing ☐ Subchondral sclerosis ☐ Osteophytes and sub-chondral cysts

☐ Yes ☐ No Does the patient have knee pain that interferes with functional activities (e.g. ambulation or prolonged standing)?
☐ Yes ☐ No Can the knee pain be attributed to any other forms of joint disease (other than osteoarthritis)?
☐ Yes ☐ No Has the patient completed conservative therapy in each joint to be treated with viscosupplementation?
- ☐ Yes ☐ No Is the patient unable to tolerate conservative therapy because of adverse side effects?
- Please indicate which of the following conservative therapies the patient completed:
  ☐ Physical therapy ☐ Acetaminophen ☐ Topical capsaicin cream ☐ NSAID's, Specify: _____
  ☐ Other: please explain: _____

☐ Yes ☐ No Has the conservative treatment resulted in functional improvement after therapy?
☐ Yes ☐ No Has the patient failed to adequately respond to aspiration and injection of intra-articular steroids?
☐ Yes ☐ No Are there any contraindications to the patient receiving viscosupplementation injections (e.g. active joint infection, bleeding disorder or skin infections at the injection site)?
☐ Yes ☐ No Is the patient scheduled to undergo a total knee replacement within 6 months of starting viscosupplementation treatment?
☐ Yes ☐ No Will the drug requested be used concomitantly with any of the following?
- Please select: ☐ With intra-articular anesthetics ☐ With intra-articular corticosteroids ☐ With intra-articular platelet rich plasma
  ☐ With intra-articular mannitol/sorbitol ☐ With intra-articular mesenchymal stem cells ☐ With another viscosupplement

☐ Yes ☐ No Does the patient have morning stiffness of less than 30 minutes in duration?
☐ Yes ☐ No Does the patient have crepitus on motion of the knee?

For All Additional Series Requests (clinical documentation required for all requests):
What product did the patient last receive? _____
Enter date of last injection from prior series: ____/____/____
☐ Yes ☐ No Have at least six months elapsed since the last injection in the prior series?
☐ Yes ☐ No Has the patient had a documented reduction in the dose of NSAID's, other anti-inflammatories, or other analgesics during the 6-month period following the previous injection series?
- ☐ Yes ☐ No Does the patient require NSAID's, other anti-inflammatories, or other analgesics for a comorbid medical condition in addition to OA of the knee? **If yes,** please identify the comorbid medical condition: _____

☐ Yes ☐ No ☐ N/A Was there a reduction in the number of intra-articular steroid injections or aspirations during the 6-month period following the series?
☐ Yes ☐ No Is there objective documentation to support significant improvement of functional capacity as a result of previous injection series?
☐ Yes ☐ No Is there objective documentation to support significant improvement in pain as a result of previous injections?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.