



**Neighborhood Health Plan Of RI**  
 Customer Service (401)-459-6020, fax 866-423-0945

**Prior Authorization Request Form**

**Hyalgan<sup>®</sup>, Euflexxa, Orthovisc<sup>®</sup>,  
 Supartz<sup>®</sup>, (Sodium Hyaluronate) Synvisc<sup>®</sup>, Synvisc-One (Hylan G-F 20)**

DATE OF REQUEST: \_\_\_\_\_

<b>MEMBER NAME:</b>		<b>MEMBER ID NUMBER OR SSN:</b>											
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<b>MEMBER DATE OF BIRTH:</b> /    /		<b>MEMBER SEX:</b> M    F    (Circle One)											
<b>PRESCRIBER NAME:</b>		<b>PRESCRIBER DEA#:</b>											
		<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>											
<b>OFFICE PHONE NUMBER:</b> (    )    -		<b>OFFICE FAX NUMBER:</b> (    )    -											
<b>PRESCRIBER SPECIALTY:</b>		<b>CONTACT PERSON AT OFFICE:</b>											

<b>INDICATE PRODUCT BEING REQUESTED (PLEASE CIRCLE ONE):</b>			
Euflexxa	Hyalgan	Orthovisc	Supartz
Synvisc-One	Synvisc	Other (please specify)	

Quantity: \_\_\_\_\_ Day Supply \_\_\_\_\_ Directions: \_\_\_\_\_ Length of Treatment: \_\_\_\_\_

Diagnosis \_\_\_\_\_ Has patient started treatment with the requested drug? \_\_\_\_\_ If yes, how many treatments? \_\_\_\_\_

NHPRI authorizes a course of hyaluronic acid injection for treatment of knee osteoarthritis provided the following three conditions are met:

1. Radiographic report documenting moderate to severe osteoarthritis of the knee(s). This documentation must be **attached. Requests submitted without proper documentation may be delayed.**
2. Failure to respond to a six week course of full dose NSAIDs (or acetaminophen if NSAIDs contraindicated)
3. Failure to respond to an intra-articular injection of corticosteroids on at least one occasion (or failure to respond for more than 6 weeks to such injection).

**INDICATIONS FOR USE**

1) Diagnosis is moderate to severe osteoarthritis of the knee(s). <b>Requests submitted without proper documentation may be delayed.</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2) Patient has attempted and failed to respond to a 6 week course of full dose NSAIDs (or acetaminophen if NSAIDs are contraindicated). <b>NSAIDS ARE CONTRAINDICATED Y/N</b> Drug/Dose _____ Dates of therapy _____ Drug/Dose _____ Dates of therapy _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3) Patient has attempted and failed to respond to an intra-articular injection of corticosteroid <b>INJECTION IS CONTRAINDICATED Y/N</b> <b>DUE TO NUMBER OF INJECTIONS GIVEN, PATIENT IS NO LONGER A CANDIDATE Y/N</b> Drug/Dose _____ Dates of therapy _____ Drug/Dose _____ Dates of therapy _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>

**BENEFIT APPROVAL**

If approval criteria are met, Neighborhood Health Plan Of RI will authorize coverage of Hyalgan<sup>®</sup> (sodium hyaluronate), Orthovisc<sup>®</sup>, Supartz<sup>®</sup> (sodium hyaluronate), or Synvisc<sup>®</sup> (Hylan G-F 20) for 1 time treatment schedule (most products are a total of 3-5 weekly injections). Thank you for your assistance.

PRESCRIBER SIGNATURE \_\_\_\_\_ NPI \_\_\_\_\_ DATE \_\_\_\_\_

*By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.*