

Neighborhood Health Plan Of RI
Customer Service (401)-459-6020, fax 866-423-0945
Prior Authorization Request Form
Hyalgan[®] (Sodium Hyaluronate), Orthovisc[®]
Supartz[®] (Sodium Hyaluronate), Synvisc[®] (Hylan G-F 20)

DATE OF REQUEST: _____

IF APPROVAL CRITERIA ARE MET, NEIGHBORHOOD HEALTH PLAN OF RI WILL AUTHORIZE COVERAGE OF HYALGAN[®] (SODIUM HYALURONATE), ORTHOVISC[®], SUPARTZ[®] (SODIUM HYALURONATE), OR SYNVISC[®] (HYLAN G-F 20). THANK YOU FOR YOUR ASSISTANCE.

MEMBER NAME:	MEMBER ID NUMBER OR SSN: <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
MEMBER DATE OF BIRTH: / /	MEMBER SEX: M F (Circle One)										

PRESCRIBER NAME:	PRESCRIBER DEA#: <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
OFFICE PHONE NUMBER: () -	OFFICE FAX NUMBER: () -										
CONTACT PERSON AT OFFICE:											

INDICATE PRODUCT BEING REQUESTED:			
HYALGAN	<input type="checkbox"/>	SYNVISC	<input type="checkbox"/>
SUPARTZ	<input type="checkbox"/>		

Quantity: _____ Day Supply _____ Directions: _____

Diagnosis _____ Length of Treatment: _____

Has patient started treatment with the requested drug? _____ If yes, how long? _____

INDICATIONS FOR USE	<u>YES</u>	<u>NO</u>
1) TREATMENT OF PAIN IN OSTEOARTHRITIS (OA) OF THE KNEE IN PATIENTS WHO HAVE FAILED TO RESPOND ADEQUATELY TO CONSERVATIVE NONPHARMACOLOGIC THERAPY, AND TO SIMPLE ANALGESICS.	<input type="checkbox"/>	<input type="checkbox"/>
2) PATIENT HAS ATTEMPTED AND FAILED LESS INVASIVE TREATMENTS: a. NONPHARMACOLOGIC THERAPY (I.E.: PHYSICAL THERAPY, EXERCISE, WEIGHT LOSS, ETC.) b. SIMPLE ANALGESICS (DEFINED BY THE MANUFACTUER AS ACETAMINOPHEN, NSAIDS, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>
3) HAS THERAPY WITH AN INTRA-ARTICULAR CORTICOSTEROID BEEN ATTEMPTED? IF NOT, PLEASE DESCRIBE WHY THIS THERAPY IS INAPPROPRIATE _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

REASONS FOR DENIAL OF BENEFIT	<u>YES</u>	<u>NO</u>
1) KNOWN HYPERSENSITIVITY TO HYALURONAN OR ANY COMPONENTS OF THE PRODUCT	<input type="checkbox"/>	<input type="checkbox"/>
2) INFECTION OR SKIN DISEASE IN THE AREA OF THE INJECTION SITE	<input type="checkbox"/>	<input type="checkbox"/>

BENEFIT APPROVAL

IF CRITERIA ARE MET, ORTHOVISC, SUPARTZ, SYNVISC, OR HYALGAN INJECTION THERAPY WILL BE APPROVED FOR 2 MONTHS
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PRESCRIBER SIGNATURE _____ NPI _____ DATE _____
By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.