

**REVIEW REQUEST FOR  
Hyaluronan Injections in the Knee  
Provider Data Collection Tool Based on Clinical Guideline DRUG-29**

Policy Last Review Date: 03/01/2017	Policy Effective Date: 03/06/2017	Provider Tool Effective Date: 03/06/2017
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Request Date:     /     /		<input type="checkbox"/> <b>Initial Authorization Request</b> <span style="margin-left: 200px;"><input type="checkbox"/> <b>Subsequent Authorization Request</b></span>	
<input type="checkbox"/> Buy and bill			
Individual's Name:		Date of Birth: /     /	
Insurance Identification Number:		Individual's Phone Number:	
Primary Diagnosis:	Diagnosis Code(s) (if known):	Individual's Weight _____ <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg)	
Ordering Provider Name & Specialty:		Provider ID Number:	
Office Address:			
Contact Name and Office Phone Number:		Office Fax Number:	
Servicing Provider Name & Specialty ( <b>If different than Ordering Provider</b> ):		Provider ID Number:	
Office Address:			
Contact Name and Office Phone Number:		Office Fax Number:	
Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Outpatient Hospital			
<input type="checkbox"/> Ambulatory Infusion <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Other: _____			
Drug Name/HCPCS Code (if known)		Dose to be administered: _____ (mg)	
Euflexxa <input type="checkbox"/> J7323	Orthovisc <input type="checkbox"/> J7324	_____ (Other)	
Gel-One <input type="checkbox"/> J7326	Supartz <input type="checkbox"/> J7321		
Gel-Syn <input type="checkbox"/> J7328	Synvisc <input type="checkbox"/> J7325		
GenVisc 850 <input type="checkbox"/> J7320			
Synvisc-One <input type="checkbox"/> J7325			
Hyalgan <input type="checkbox"/> J7321			
Hymovis <input type="checkbox"/> J7322			
Monovisc <input type="checkbox"/> J7327			
Other: _____			
When did the individual first start this drug? /     /		Frequency For This Request (Days, Wks, Months) _____	
Duration For This Request: _____ (Weeks)		Start Date For This Request: /     /	

This clinical guideline based data collection tool is for a medical necessity review request for **initial and repeat hyaluronan injections** for the replacement or supplementation of naturally occurring intra-articular lubricants in individuals with *osteoarthritis in the knees* (also known as viscosupplementation).

**Please check all of the following that apply to the individual.**

**1. Initial Request for hyaluronan treatment of the knee**

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- The request is for** an initial course of intra-articular injections of hyaluronan
  - A diagnosis of osteoarthritis of the knee has been documented
  - Individual has pain due to osteoarthritis of the knee
  - There is no evidence of inflammatory arthritis (for example, rheumatoid arthritis)
  - There is documentation that the pain interferes with functional activities (for example, ambulation, prolonged standing)
  - There is documentation of failure to respond adequately to at least 3 months of conservative therapy. (IF checked, mark all of the following that apply to the individual)
    - Activity modification,
    - Home exercise,
    - Protective weight bearing
    - Analgesics (for example, acetaminophen or non-steroidal anti-inflammatory drugs [NSAIDs])
    - The individual is unable to tolerate conservative therapy because of adverse side effects
    - Other \_\_\_\_\_
- There are no contraindications to the injections (for example, active joint infection, bleeding disorder).

### 2. Repeat Course of intra-articular injections of hyaluronan treatment of the knee

- The individual has met all of the criteria for an initial course of treatment (**listed above**)
- Six (6) months, or more, have elapsed since the conclusion of the prior treatment cycle
- Provide the completion date of the most recent intra-articular injection of hyaluronan treatment of the knee:  
\_\_\_\_\_
- There is documentation that the individual has experience pain relief and improvement in functional status from the prior course of hyaluronan treatment
- Other \_\_\_\_\_

2. **Other Use(s)** (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

### Note to Providers: Clinically Equivalent Cost Effective Agents

When hyaluronan is determined to be medically necessary, the benefit plan may have, in addition, a medically necessary criterion that the treatment be cost effective. When such language exists, the benefit plan may determine which hyaluronan therapy is covered. For plans that only review for the benefit plan criterion that the treatment be cost effective, when such language exists, the benefit plan may determine which hyaluronan therapy is covered.

A benefit plan may select any one or more of the following as clinically equivalent cost effective hyaluronan agents: Euflexxa<sup>®</sup> (1% sodium hyaluronate); Gel-One<sup>®</sup> (sodium hyaluronate); Gelsyn<sup>™</sup> (sodium hyaluronate); Gen Visc 850<sup>®</sup> (sodium hyaluronate); Hyalgan<sup>®</sup> (sodium hyaluronate); Hymovis<sup>®</sup> (hyaluronic acid); Monovisc<sup>®</sup> (sodium hyaluronate); Orthovisc<sup>®</sup> (hyaluronic acid); Supartz FX<sup>™</sup> (sodium hyaluronate); Synvisc<sup>®</sup> (hylan G-F 20); Synvisc-One<sup>®</sup> (hylan G-F 20).

***Please check the member's benefit plan for any preferred cost effective agents.***

In benefit plans where there is a requirement to use a cost effective hyaluronan agent, requests for a hyaluronan agent which is NOT cost effective may be approved when the individual has had a trial and inadequate response or intolerance to one cost effective agent.

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This request is being submitted:

- Pre-Claim  
 Post-Claim. If checked, please attach the claim or indicate the claim number \_\_\_\_\_

I confirm that the information entered on this form is accurate and complete based on the records available at the time of this request. I understand the health plan or its designees may request medical documentation to verify the accuracy of the information reported on this form.

\_\_\_\_\_/ / Date  
Name & Title of Provider or Provider Representative Completing Form  
& attestation (Please Print)\*

**\*The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

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