Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Hyaluronic Acid Derivatives (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Hyaluronic Acid Derivatives (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

Specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis:_____ **ICD Code:**_____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 6.]

2. Is this a request for retreatment of the same knee? Y N

   [If no, skip to question 6.]

3. Has the member received 2 or more SERIES of injections in this knee? Y N

   [If yes, then no further questions]

4. Has it been at least 6 months since the last course of injections for Y N

this knee?

[If no, then no further questions.]

5. Is the member responding to treatment? Y N

   Please provide documentation to support improved response to the previous series (example: dose reduction with NSAIDs or other analgesics)

   [No further questions.]

6. Does the member report pain which interferes with functional activities (example: ambulation, prolonged standing)? Y N

   [If no, then no further questions.]

7. Can the pain be attributed to other forms of joint disease? Y N

   [If yes, then no further questions.]

8. Is treatment being requested for any of the following indications: A) Temporomandibular joint disorders, B) Chondromalacia of patella (chondromalacia patellae), C) Pain in joint, lower leg (patellofemoral syndrome), D) Osteoarthrosis and allied disorders (joints other than the knee) E) Diagnosis of osteoarthritis of the hip, hand, shoulder, etc. Y N

   [If yes, then no further questions.]

9. Is there radiographic evidence of mild to moderate osteoarthritis of the knee (e.g., severe joint space narrowing, subchondral sclerosis, osteophytes)? Y N

   Please document which knee is being treated: _____

   [If yes, skip to question 11.]

10. Does the member have documented symptomatic osteoarthritis of the knee according to the American College of Rheumatology (ACR) clinical and laboratory criteria, which requires knee pain and at least FIVE of the following: A) Bony enlargement, B) Bony tenderness, C) Crepitus (noisy, grating sound) on active motion, D) Erythrocyte sedimentation rate (ESR) less than 40 mm/hr, E) Less than 30 minutes of morning stiffness, F) No palpable warmth of synovium, G) Over 50 years of age, H) Rheumatoid factor less than 1:40 titer (agglutination method), I) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3) Y N

    Please list the characteristics the member meets:

_____

[If no, then no further questions.]

11. Has the member had an inadequate response, intolerable side effect, or contraindication to conservative non-pharmacologic therapy (examples: physical therapy, land based or aquatic based exercise, weight loss, resistance training)? Y N

    Please indicate non-pharmacologic therapy tried and reason for discontinuation:

    _____

    [If no, then no further questions]

12. Has the member had an inadequate response, intolerable side effect, or contraindication to an adequate trial of pharmacologic therapy such as NSAIDs (oral or topical), acetaminophen, or topical capsaicin? Y N

    If yes, please list drugs tried here, side effect, or contraindication:

    _____

    [If no, then no further questions]

13. Has the member had an inadequate response, intolerable side effect, or contraindication to intra-articular steroid injections? Y N

    If yes, please document date of last steroid injection, side effect, or contraindication: _____

    [If no, then no further questions]

14. Has the member had surgery on the same knee in the past 6 months? Y N

    [If yes, then no further questions.]

15. Is this request for either Hyalgan or Gel-One? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**