OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Hyaluronic Acid Derivatives Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: / Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the medication being requested below:

❑ Durolane	❑ Gelsyn-3	❑ Hymovis	❑ Supartz	❑ Synvisc-One
❑ Euflexxa	❑ Genvisc 850	❑ Monovisc	❑ Supartz FX	❑ TriVisc
❑ Gel-One	❑ Hyalgan	❑ Orthovisc	❑ Synvisc	❑ Visco-3

Select the diagnosis below:

❑ Osteoarthritis of the knee
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication History:

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:
- ❑ Acetaminophen
- ❑ Formulary non-steroidal anti-inflammatory drugs (NSAIDs)
- ❑ Tramadol
- ❑ Intra-articular steroid injection

For Durolane, Gel-One, Gelsyn-3, Genvisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz or Supartz FX, TriVisc, or Visco-3 requests only:

Select if the patient has had a trial and failure, contraindication, or intolerance to the following hyaluronic acid derivatives:
- ❑ Euflexxa
- ❑ Synvisc
- ❑ Synvisc-One

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had improvement in pain with the previous course of treatment? ❑ **Yes** ❑ **No**

Have at least 6 months elapsed since the last injection of the prior treatment cycle? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.