



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 <small>(required)</small> | | | Provider Information <small>(required)</small> | | |
|--|--------|------|--|--------|------------|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | | Specialty: |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information <small>(required)</small> | | | |
|---|--|---------------------|--------------|
| Medication Name: | | Strength: | Dosage Form: |
| <input type="checkbox"/> Check if requesting brand | | Directions for Use: | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | | |

Clinical Information (required)

Select the medication being requested below:

Euflexxa
 Orthovisc
 Synvisc
 Synvisc-One

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) (e.g., ibuprofen, naproxen)
- Tramadol
- Intra-articular steroid injection (e.g., methylprednisolone, triamcinolone)

For Orthovisc requests, also answer the following:

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:

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 1-844-403-1029.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
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