Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS

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 Illinois at **1-855-684-5250**.
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 *(please circle)*

Drug, please specify_____

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:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? [If no, skip to question 6.] Y N
2. Is this a request for retreatment of the same knee? [If no, skip to question 6.] Y N
3. Has the patient received 2 or more SERIES of injections in this knee? [If yes, then no further questions] Y N
4. Has it been at least 6 months since the last course of injections for this knee? Y N

[If no, then no further questions.]

5. Is the patient responding to treatment? Y N
   Please provide details of symptom improvement:
   _____
   [No further questions.]

6. Does the knee pain interfere with the patient's daily functioning or activities? Y N
   [If no, then no further questions.]

7. Is the patient at least 18 years of age? Y N
   [If no, then no further questions.]

8. 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, then skip to question 10.]

9. Does the patient have painful, symptomatic osteoarthritis of the knee as evidenced by 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) Normal synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3) Y N

   Please list the characteristics the patient meets:
   _____
   [If no, then no further questions.]

10. Has the patient tried and failed conservative nonpharmacologic therapy (e.g., physical therapy, weight loss, resistance training)? Y N

    Please indicate non-pharmacologic therapy tried and reason for failure:
    _____
    [If no, then no further questions]

11. Has the patient tried and failed other medications (i.e., NSAIDs, acetaminophen, or tramadol)? Y N

    If yes, please list drugs tried here:
    _____

[If no, then no further questions]

12. Has the patient tried and failed intra-articular corticosteroids? Y N
    If yes, please document date of last steroid injection:
    _____
    [If no, then no further questions]

13. 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