04/29/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Hyaluronic Acid Derivatives (IL88)

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 Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Hyaluronic Acid Derivatives (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Euflexxa (1% sodium hyaluronate)	Hyalgan (sodium hyaluronate)	Orthovisc (hyaluronan)
Supartz (sodium hyaluronate)	Synvisc (hylan G-F 20)	Synvisc One (hylan G-F 20)

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: ___________________________
Physician Phone: ___________________________
Physician Fax: ___________________________
Physician Address: ___________________________
City, State, Zip: ___________________________

Diagnosis:______________________________ **ICD Code:**______________________________

Please circle the appropriate answer for each question.

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

   [If yes, skip to question 4.]

2. Does the patient have a diagnosis of osteoarthritis of the knee? Y N

   [If no, no further questions.]

3. Is the patient at least 18 years of age? Y N

Is the patient at least 18 years of age?

[If no, no further questions.]

4. Reauthorization Requests: For retreatment of same knee. Has it been at least 6 months since the last course of viscosupplementation for this knee? If the answer is yes, please provide name of drug, date of last injection and which knee(s) was treated: Y N

   [If yes, no further questions.]

5. Reauthorization Requests: For initial treatment of other/untreated knee. Is the request for treatment of patient's other knee? Y N

   [If no, no further questions.]

6. Has the following documentation been submitted? Radiographic evidence of severe osteoarthritis of the knee (e.g., severe joint space narrowing, bone-on-bone, osteophytes) \ Which knee (Left, Right, or Both Knees) will be treated - please indicate: Y N

   [If no, no further questions.]

7. Has the patient had a trial and failure of or contraindication to conservative nonpharmacologic therapy (e.g., cane or walker, physical therapy, weight loss)? If yes, please indicate non-pharmacologic therapy tried and document failure or contraindication: Y N

   [If no, no further questions.]

8. Has the patient failed a trial of NSAIDs (e.g., diclofenac, etodolac, ibuprofen, indomethacin, ketoprofen, meloxicam, nabumetone, naproxen, or oxaprozin) and acetaminophen? If yes, please list drugs tried here: Y N

   [If yes, skip to question 10.]

9. Does the patient have a contraindication to NSAIDs (e.g., diclofenac, etodolac, ibuprofen, indomethacin, ketoprofen, meloxicam, nabumetone, naproxen, or oxaprozin) and acetaminophen? If yes, please list drugs and contraindication: Y N

   [If no, no further questions.]

10. Has the patient had a trial and failure of intra-articular corticosteroids, if indicated? Y N

[No further questions.]

Comments:

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

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Prescriber (Or Authorized) Signature **Date**