BlueCross BlueShield
Federal Employee Program.

HYALURONIC ACID AGENTS PRIOR APPROVAL REQUEST

Send completed form to:
Blue Shield of California
Fax: 1-855-895-3504

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER COMPLETES

Date: ____ / ____ / ____

Patient Name: ________________________/ ______ / ______________________________
First MI Last

Patient Address: ____
Street City State Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ____ F _____

R [| | | | | | |]
Cardholder Identification Number

PHYSICIAN COMPLETES

Please select drug:

❑**Gel-One*** ❑**Hyalgan*** ❑**Supartz*** ❑Euflexxa ❑GelSyn-3 ❑Durolane ❑Visco-3
❑Monovisc ❑Orthovisc ❑Synvisc ❑Synvisc-One ❑Hymovis ❑GenVisc 850

*** Gel-One, GelSyn-3, Hyalgan, and Supartz are preferred/participating products. Please consider prescribing a preferred/participating product.**
Non-participating products require additional information to be provided (Question 3 below)

NOTE: Form must be completed in its entirety for processing

1) What is the patient's diagnosis?
❑Osteoarthritis (OA, DJD): Location: ❑Left knee only ❑Right knee only ❑Both knees
❑Other form or location of arthritis: ____
❑Other Diagnosis (please specify): ____

2) Is this the INITIATION or CONTINUATION of therapy?
❑**INITIATION**
a. Has the patient failed to achieve an adequate response to two or more of the following:

Cardiovascular (aerobic) activity, such as walking, biking, stationary bike, aquatic activity ❑ Yes ❑No		
Resistance exercise ❑ Yes ❑No	Weight reduction ❑ Yes ❑No	Thermal agents ❑ Yes ❑No
Wearing of medically directed patellar taping ❑ Yes ❑No	Wearing of wedged insoles ❑ Yes ❑No	Participation in self-management programs ❑ Yes ❑No
Walking aids ❑ Yes ❑No	Physical therapy ❑ Yes ❑No	Occupational therapy ❑ Yes ❑No
Other failed therapy (please specify): ____		

b. Has the patient failed to achieve an adequate response to **TWO** or more of the following ~~analgesics~~:
Acetaminophen (Tylenol), oral NSAIDs (e.g. ibuprofen, naproxen, etc.), topical NSAIDs? ❑Yes ❑No
❑If Yes, please specify failed prior analgesics: ___________________________
❑Patient has a contraindication or intolerance to the above analgesics

c. Has the patient had an inadequate response, intolerance, or contraindication to intra-articular steroid injections (such as betamethasone, methylprednisolone, triamcinolone) in which the efficacy lasted less than 8 weeks? ❑Yes ❑No

d. Is there radiologic confirmation of Kellgren-Lawrence score of grade 2 or greater? ❑Yes ❑No

❑**CONTINUATION**
a. Is there documented improvement in pain with the previous course of treatment? ❑Yes ❑No
b. Has at least 12 months elapsed since the last injection of the prior treatment cycle? ❑Yes ❑No
c. Has there been a documented reduction of dosing of NSAIDs or other analgesics during the 12 month period following the last injection of the prior treatment cycle? ❑Yes ❑No

3) If requested drug is Durolane, Euflexxa, Gel-Syn, Gen Visc, Hymovis, Monovisc, Orthovisc, Synvisc/Synvisc-One or Visco-3:

Please indicate **all** of the following drugs the patient has tried and failed:

❑Gel-One ❑GelSyn-3 ❑Hyalgan ❑Supartz ❑The patient has not tried and failed Gel-One, GelSyn-3, Hyalgan, and/or Supartz

Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

____________________ (____) ____________ (____) ____________

Physician Name (Print Clearly) Phone Fax

____________________ ____________ ______ ______

Street Address City State Zip

____________ ____________________ ____ / ____ / ____

Prescriber's NPI Physician Signature Date