Intra Articular Hyaluronan Injections for Treatment of Osteoarthritis of the Knee

INTRA-ARTICULAR INJECTION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

PRIOR REVIEW/CERTIFICATION REQUEST FOR SERVICES FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
Provider Name		Servicing Provider	
Provider #, Tax ID # or NPI		Facility Name	
Street, Bldg., Suite #		Servicing provider or Facility #, or NPI #	
City/State/Zip code		Street, Bldg., Suite #	
Phone #		City/State/Zip code	
Fax #			

PLACE OF SERVICE: ☐ Home Infusion ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE:	**CPT/other billing codes:**
Primary Diagnosis:	**ICD-10:**
Drug Requested:	
Strength & Route of Administration:	

Please select the requested medication and answer the following questions for INITIAL coverage:

**See pages 3-4 for continuation coverage; see pages 5-6 for quantity limit exceptions.*

☐ Durolane®	J7318	☐ Hymovis®	J7322	☐ Synojoynt™	J7331
☐ Euflexxa®	J7323	☐ Hymovis One®	J7322	☐ Synvisc®	J7325
☐ Gelsyn-3®	J7328	☐ Monovisc®	J7327	☐ Synvisc-One®	J7325
☐ Gel-One®	J7326	☐ Orthovisc®	J7324	☐ Triluron™	J7332
☐ GenVisc® 850	J7320	☐ Supartz®	J7321	☐ TriVisc™	J7329
☐ Hyalgan®	J7321	☐ Supartz® FX	J7321	☐ Visco-3™	J7321

1. Please select where the injection(s) will be administered by a healthcare professional:
   a. Left knee?..... ☐ Yes ☐ No
   b. Right knee?..... ☐ Yes ☐ No
   c. Both knees?..... ☐ Yes ☐ No
   d. Other: _____
2. Is the requested medication being used for pain relief for osteoarthritis of the knee?..... ☐ Yes ☐ No
3. Does the patient have evidence of joint space narrowing, sub-chondral sclerosis, osteophytes, and/or sub-chondral cysts present on radiographs?..... ☐ Yes ☐ No

****continued on page 2; sign page 2 for prior authorization****

BlueCross BlueShield of North Carolina

Intra Articular Hyaluronan Injections for Treatment of Osteoarthritis of the Knee - *continued*

4. Does the patient have knee pain accompanied by any of the following:
   a. Crepitus on active motion?..... ☐ Yes ☐ No
   b. Erythrocyte sedimentation rate (ESR) less than 40 mm/hr?..... ☐ Yes ☐ No
   c. Bony enlargement?..... ☐ Yes ☐ No
   d. Bony tenderness?..... ☐ Yes ☐ No
   e. Less than 30 minutes of morning stiffness?..... ☐ Yes ☐ No
   f. No palpable warmth of synovium?..... ☐ Yes ☐ No
   g. Over 50 years of age?..... ☐ Yes ☐ No
   h. Rheumatoid factor less than 1:40 titer (agglutination method)?..... ☐ Yes ☐ No
   i. Synovial fluid signs (clear fluid of normal viscosity and white blood cells less than 2000/mm^3)?..... ☐ Yes ☐ No
5. Is the patient scheduled to undergo a total knee replacement within 6 months of starting therapy with the requested medication?..... ☐ Yes ☐ No
6. Has the patient tried and had an inadequate response to conservative non-pharmacologic therapy (e.g., exercise, physical therapy, weight loss) for at least 3 months?..... ☐ Yes ☐ No
   a. **If NO,** does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to conservative non-pharmacologic therapy?..... ☐ Yes ☐ No
7. Has the patient tried and had an inadequate response to pharmacologic therapy with simple analgesics (e.g., acetaminophen or non-steroidal anti-inflammatory drugs [NSAIDs]) for at least 3 months?..... ☐ Yes ☐ No
   a. **If NO,** does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to pharmacologic therapy with simple analgesics?..... ☐ Yes ☐ No
8. Is the request for Synvisc, Synvisc-One, or Orthovisc?..... ☐ Yes ☐ No
   If NO, please answer the following questions:
   a. Has the patient tried and failed or has a clinical contraindication to Synvisc **OR** Synvisc-One?..... ☐ Yes ☐ No
      If YES, please submit medical record documentation.
   b. Has the patient tried and failed or has a clinical contraindication to Orthovisc?..... ☐ Yes ☐ No
      If YES, please submit medical record documentation.
9. Is the requested quantity within the maximum units allowed for one course of treatment (see table on page 6)?..... ☐ Yes ☐ No
   If NO, please complete page 5 for a quantity limit exception.

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-888-348-7332

Intra Articular Hyaluronan Injections for Treatment of Osteoarthritis of the Knee - CONTINUATION

INTRA-ARTICULAR INJECTION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility #, or NPI #**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #			

PLACE OF SERVICE: ☐ Home Infusion ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE:	**CPT/other billing codes:**
Primary Diagnosis:	**ICD-10:**
Drug Requested:	
Strength & Route of Administration:	

Please select the requested medication and answer the following questions for <u>CONTINUATION</u> coverage:

☐ Durolane®	J7318	☐ Hymovis®	J7322	☐ Synojoynt™	J7331
☐ Euflexxa®	J7323	☐ Hymovis One®	J7322	☐ Synvisc®	J7325
☐ Gelsyn-3®	J7328	☐ Monovisc®	J7327	☐ Synvisc-One®	J7325
☐ Gel-One®	J7326	☐ Orthovisc®	J7324	☐ Triluron™	J7332
☐ GenVisc® 850	J7320	☐ Supartz®	J7321	☐ TriVisc™	J7329
☐ Hyalgan®	J7321	☐ Supartz® FX	J7321	☐ Visco-3™	J7321

1. Was the patient approved for initial coverage for the requested medication through Blue Cross NC?.....☐ Yes ☐ No
   If NO, please answer all questions on pages 1-2.
2. Please select where the injection(s) will be administered by a healthcare professional:
   a. Left knee?.....☐ Yes ☐ No
   b. Right knee?.....☐ Yes ☐ No
   c. Both knees?.....☐ Yes ☐ No
   d. Other: _____

****continued on page 4; sign page 4 for prior authorization****

Intra Articular Hyaluronan Injections for Treatment of Osteoarthritis of the Knee - *continued*

3. Has the patient had a reduction in the required dose of analgesics / anti-inflammatory medications following the previous series of injections?.....☐ Yes ☐ No
   If YES, please submit medical record documentation.
4. Has the patient demonstrated significant improvement in pain and functional capacity following the previous series of injections?.....☐ Yes ☐ No
   If YES, please submit medical record documentation.
5. Have at least 6 months lapsed since the completion of the previous injection treatment course for the same knee?.....☐ Yes ☐ No
6. Is the requested quantity within the maximum units allowed for one course of treatment (see table on page 6)?.....☐ Yes ☐ No
   If NO, please complete page 5 for a quantity limit exception.

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-888-348-7332

Intra Articular Hyaluronan Injections for Treatment of Osteoarthritis of the Knee - QUANTITY LIMIT EXCEPTION

INTRA-ARTICULAR INJECTION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility #, or NPI #**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #			

PLACE OF SERVICE: ☐ Home Infusion ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE:	**CPT/other billing codes:**
Primary Diagnosis:	**ICD-10:**

FOR COVERAGE OVER THE FDA LABELED DOSING (SEE PAGE 6), PLEASE SELECT THE REQUESTED MEDICATION AND ANSWER THE FOLLOWING QUESTIONS:

Please note: This medication requires a prior authorization before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (pages 1-2 or 3-4). Otherwise, this request will deny.

☐ Durolane®	J7318	☐ Hymovis®	J7322	☐ Synojoynt™	J7331
☐ Euflexxa®	J7323	☐ Hymovis One®	J7322	☐ Synvisc®	J7325
☐ Gelsyn-3®	J7328	☐ Monovisc®	J7327	☐ Synvisc-One®	J7325
☐ Gel-One®	J7326	☐ Orthovisc®	J7324	☐ Triluron™	J7332
☐ GenVisc® 850	J7320	☐ Supartz®	J7321	☐ TriVisc™	J7329
☐ Hyalgan®	J7321	☐ Supartz® FX	J7321	☐ Visco-3™	J7321

Requested units: _____

Please enter quantity as a numeric value with one decimal place (ex. 1.0, 1.5)*

Per: ☐ Left knee ☐ Right knee ☐ Both knees ☐ Other: _____

In the space provided, please document support for the requested Quantity Limit Exception (this may include documented clinical rationale and/or medical records).

_____

_____

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required):_____ **Date**:_____

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QUANTITY LIMITS

Intra Articular Hyaluronan Injections for Treatment of Osteoarthritis of the Knee

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Medication**	Injections per Treatment Course	Billable Units per Injection	HCPCS	Maximum Units*
Durolane	1	60	J7318	60 (one knee) 120 (both knees)
GenVisc 850	3-5	25	J7320	125 (one knee) 250 (both knees)
Hyalgan	3-5	1	J7321	5 (one knee) 10 (both knees)
Supartz	3-5	1	J7321	5 (one knee) 10 (both knees)
Supartz FX	3-5	1	J7321	5 (one knee) 10 (both knees)
Hymovis	2	24	J7322	48 (one knee) 96 (both knees)
Hymovis One	1	32	J7322	32 (one knee) 64 (both knees)
Euflexxa	3	1	J7323	3 (one knee) 6 (both knees)
Orthovisc	3-4	1	J7324	4 (one knee) 8 (both knees)
Synvisc	3	16	J7325	48 (one knee) 96 (both knees)
Synvisc-One	1	48	J7325	48 (one knee) 96 (both knees)
Gel-One	1	1	J7326	1 (one knee) 2 (both knees)
Monovisc	1	1	J7327	1 (one knee) 2 (both knees)
Gelsyn-3	3	168	J7328	504 (one knee) 1008 (both knees)
TriVisc	3	25	J7329	75 (one knee) 150 (both knees)
Synojoynt	3	20	J7331	60 (one knee) 120 (both knees)
Triluron	3	20	J7332	60 (one knee) 120 (both knees)
Visco-3	3	1	J7321	3 (one knee) 6 (both knees)

***Maximum units allowed for duration of approval**

**all products administered as intra-articular (IA) injections