Osteoarthritis

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: ______________________________ **Date**: ________________________________
Patient's ID: _____________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ____________________

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: __________________________*kg*

*Patient Height:*___________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

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Criteria Questions:

1. What is the ICD-10 code? ________________

2. What drug is being prescribed?
   Preferred Products - Indicate and no further questions:
   ❑ Hyalgan
   ❑ Hymovis
   ❑ Synvisc
   ❑ Synvisc One

   Non-Preferred Products - Indicate and Continue:
   ❑ Euflexxa ❑ Gel-one ❑ Gelsyn-3
   ❑ GenVisc 850 ❑ Monovisc ❑ Orthovisc
   ❑ Supartz FX ❑ Visco-3 ❑ Durolane
   ❑ Other _________________________

3. The preferred hyaluronate products for your patient's plan are Hyalgan (sodium hyaluronate), Hymovis (high molecular weight viscoelastic hyaluronan), Synvisc (hylan G-F 20) and Synvisc One (hylan G-F 20). Can the patient's treatment be switched to one of the preferred products?
   ❑ Yes – Hyalgan, *no further questions*
   ❑ Yes – Hymovis, *no further questions*
   ❑ Yes – Synvisc, *no further questions*
   ❑ Yes – Synvisc One, *no further questions*
   ❑ No

4. Is the patient in the middle of a treatment course (i.e., patient requires additional injection(s) to complete the current treatment course for the affected joint)?
   Number of injections per treatment course
   - Euflexxa: 3 injections (2 mL each; 6 mL total) per course
   - Gelsyn-3: 3 injections (2 mL each, 6 mL total) per course
   - GenVisc 850: 3 to 5 injections (2.5 mL each; 12.5 mL total)
   - Orthovisc: 3 or 4 injections (2 mL each; 8 mL total) per course
   - Supartz FX: 3 to 5 injections (2.5 mL each; 12.5 mL total) per course

   ❑ Yes – *Indicate dates and affected joints below and skip to Question 9.*
   ❑ No

   A) Date of Injection: ___________________________ B) Affected Joint: ______________________
   B) Date of Injection: ___________________________ B) Affected Joint: ______________________
   C) Date of Injection: ___________________________ B) Affected Joint: ______________________
   D) Date of Injection: ___________________________ B) Affected Joint: ______________________

5. Has the patient experienced a documented intolerable adverse event to Hyalgan, Hymovis, and Synvisc or Synvisc One? **Action Required**: ***If 'Yes', please attach supporting chart note(s).*** ❑ Yes ❑ No

6. What is the diagnosis?
   ❑ Osteoarthritis of the knee
   ❑ Osteoarthritis of the hip
   ❑ Osteoarthritis of the shoulder
   ❑ Other ____

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CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-866-814-5506 ● Fax: 1-855-330-1720 ● www.caremark.com

Step Therapy Override: Complete if Applicable.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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