2211 Sanders Road, Northbrook, IL 60062 Phone (866) 814-5506

Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}

To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}

Electronically (4-5 **minutes** process time)	**Phone** (10-15 **minutes** process time)	**Fax** (24-72 **hours** process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Osteoarthritis

Prior Authorization Request

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 **1-888-877-0518.** 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}
Patient's ID: {Auth.Member.MemberID}

Date: {System.DateTime.Today}

Patient's Date of Birth: {Auth.Member.MemberBirthDate}

Physician's Name: {Auth.ProviderBilling.Name.Legal}
Specialty: _____
Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

NPI#: {Auth.ProviderBilling.NPI}
Physician Office Fax: {Auth.OfficeContactFaxNumber}

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*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

Exception Criteria Questions:

A. What drug is being prescribed?
Preferred Products - Indicate and no further questions:
❑ Euflexxa
❑ Monovisc
❑ Orthovisc

Other Products:

❑ Durolane	❑ Gel-one	❑ Gelsyn-3	❑ GenVisc 850	❑ Hyalgan
❑ Hymovis	❑ Supartz FX	❑ Synvisc	❑ Synvisc One	❑ Trivisc
❑ Visco-3	❑ Synojoynt *Skip to Criteria Questions*		❑ Triluron *Skip to Criteria Questions*	

❑ Other _____

B. Is the product being requested for the treatment of osteoarthritis of the knee?
❑ Yes ❑ No, *If No, skip to Criteria Questions*

C. The preferred hyaluronate products for your patient's plan are Euflexxa, Monovisc, and Orthovisc. Can the patient's treatment be switched to one of the preferred products?
❑ Yes – Euflexxa, *no further questions*
❑ Yes – Monovisc, *no further questions*
❑ Yes – Orthovisc, *no further questions*
❑ No

D. Is the request for Durolane, Gel-One or Synvisc One? ❑ Yes, *If Yes, skip to Question F* ❑ No

E. Is there documentation that the patient is currently undergoing treatment and coverage is required to complete the current course of treatment (i.e., patient requires additional injection(s) to complete the current treatment course for the affected joint)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s)***.
Number of injections per treatment 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) per course
- Hyalgan: 3 to 5 injections (2 mL each; 10 mL total) per course
- Hymovis: 2 injections (3 mL each; 6 mL total) per course
- Supartz FX: 3 to 5 injections (2.5 mL each; 12.5 mL total) per course
- Synvisc: 3 injections (2ml each, 6 ml total) per course
- Trivisc: 3 injections (3ml each, 9 ml total) per course
- Visco-3: 3 injections (2.5ml each, 7.5ml total) per course

❑ Yes – *Indicate dates and affected joints below and skip to criteria questions*
❑ 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: _____

F. Has the patient experienced a documented intolerable adverse event to all of the preferred products (Euflexxa, Monovisc, Orthovisc)? ***ACTION REQUIRED: If 'Yes', please attach supporting chart note(s).***
❑ Yes ❑ No

Criteria Questions:
What is the ICD-10 code? _____

1. What is the prescribed medication?
❒ Gel-One, *Continue to 2*
❒ Gelsyn-3, *Continue to 2*
❒ Supartz FX, *Continue to 2*
❒ Visco-3, *Continue to 2*

❒ Durolane, *Continue to 2*

❒ Euflexxa, *Continue to 2*

❒ GenVisc 850, *Continue to 2*

❒ Hyalgan, *Continue to 2*

❒ Hymovis, *Continue to 2*

❒ Monovisc, *Continue to 2*

❒ Orthovisc, *Continue to 2*

❒ Synojoynt, *Continue to 2*

❒ Synvisc, *Continue to 2*

❒ Synvisc One, *Continue to 2*

❒ TriVisc, *Continue to 2*

❒ Triluron, *Continue to 2*

❒ 1% sodium hyaluronate, *Continue to 2*

2. What is the diagnosis?

   ❒ Osteoarthritis of the knee, *Continue to 3*

   ❒ Other, please specify. _____, *Continue to 3*

3. Is the diagnosis supported by radiographic evidence of osteoarthritis of the knee, such as joint space narrowing, subchondral sclerosis, osteophytes, and sub-chondral cysts?
   ❒ Yes, *Continue to 5*
   ❒ No, *Continue to 4*

4. At the time of diagnosis, did/does the patient have at least 5 of the following signs and symptoms: A) Bony enlargement, B) Bony tenderness, C) Crepitus (noisy, grating sound) on active motion, D) Erythrocyte sedimentation rate (ESR) less than 40 mm per hour, 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), or I) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3)?
   ❒ Yes, *Continue to 5*
   ❒ No, *Continue to 5*

5. Does the patient have knee pain which interferes with functional activities (e.g., ambulation, prolonged standing)?
   ❒ Yes, *Continue to 6*
   ❒ No, *Continue to 6*

6. Has the patient experienced an inadequate response or adverse effects with non-pharmacologic treatment options (e.g., physical therapy, regular exercise, insoles, knee bracing, weight reduction)?
   ❒ Yes, *Continue to 7*
   ❒ No, *Continue to 7*

7. Has the patient experienced an inadequate response or intolerance to a trial of an analgesic (e.g., acetaminophen up to 3 to 4 grams per day, non-steroidal anti-inflammatory drugs [NSAIDs], topical capsaicin cream) for at least 3 months?
   ❒ Yes, *Continue to 9*
   ❒ No, *Continue to 8*

8. Does the patient have a contraindication to a trial of an analgesic (e.g., acetaminophen up to 3 to 4 grams per day, non-steroidal anti-inflammatory drugs [NSAIDs], topical capsaicin cream) for at least 3 months?
   ❒ Yes, *Continue to 9*
   ❒ No, *Continue to 9*
9. Has the patient experienced an inadequate response or intolerance to a trial of intraarticular steroid injections for at least 3 months?
   ❒ Yes, *Continue to 11*
   ❒ No, *Continue to 10*
10. Does the patient have a contraindication to a trial of intraarticular steroid injections for at least 3 months?
    ❒ Yes, *Continue to 11*
    ❒ No, *Continue to 11*
11. Is the patient scheduled to undergo a total knee replacement within 6 months of starting treatment?
    ❒ Yes, *Continue to 12*
    ❒ No, *Continue to 12*
12. Please indicate if this request is for initiation of therapy (first time use), continuation of therapy (in the middle of a treatment series), or re-start of therapy (the patient has been treated with a viscosupplementation in the past).

    ❒ Initiation of therapy (first time use), *No further questions*

    ❒ Continuation of therapy (the patient is in the middle of therapy), *No further questions*

    ❒ Re-start of therapy (the patient has received a viscosupplementation in the past), *Continue to 13*
13. Has the patient experienced improvement in pain and functional capacity following the previous injections?
    ❒ Yes, *Continue to 14*
    ❒ No, *Continue to 14*
14. Was the previous series of injections completed at least 6 months prior to this request?
    ❒ Yes, *No Further Questions*
    ❒ No, *No Further Questions*

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)**

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com