Prior Authorization Request Form for Intra-Articular Hyaluronates

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:
Joint to be injected:	Dosage Form (vial, syringe):	

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Does the member have a history of contraindication to the prescribed medication?
☐ Yes
☐ No

Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Intra-Articular Hyaluronate? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*
☐ Yes
☐ No
*Medications Taken (start and end date and dose):*_____
_____
_____
_____

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

INITIAL REQUESTS:

☐ Documented history of therapeutic failure, contraindication or intolerance to ALL of the following: (medication, start date and end date)
- ☐ Non-pharmacologic treatment:_____
- ☐ Acetaminophen or Non-steroidal anti-inflammatory drug (NSAIDs):_____
- ☐ Intra-articular glucocorticoid injection:_____

RENEWAL REQUESTS:

☐ Documentation improvement in pain or joint function following the first treatment:_____
☐ Member has not received an Intra-Articular Hyaluronate in the same joint within the past 6 months
- ☐ Date of last injection:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)