INTRA-ARTICULAR HYALURONATES PRIOR AUTHORIZATION FORM *(form effective 7/6/2026)*

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/
Prior authorization guidelines for **Intra-Articular Hyaluronates** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested:	Dosage form (syringe, vial, etc.):
Joint(s) to be injected: ☐right knee ☐left knee ☐other** (specify):_____ *(**For consideration of treatment for other joints/indication, submit clinical documentation of diagnosis, medical literature supporting the use of the requested agent for the diagnosis, and other therapies that have been tried.)*	
Frequency of injection:	Requested duration of therapy:
Diagnosis:	Dx code (required):
***Requests for a non-preferred agent*:** Does the member have a history of trial and failure of or a contraindication or an intolerance to the preferred Intra-articular Hyaluronates? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.*	☐Yes – *Submit all supporting documentation of trial and failure, contraindications, & intolerances.* ☐No

INITIAL requests

Does the member have a history of trial and failure of or a contraindication or an intolerance to any other pharmacologic and non-pharmacologic therapies?

- *Check all that apply and record specific treatment/therapy.*
- *SUBMIT DOCUMENTATION of treatments/therapies tried (or cannot be tried), dates and durations, and outcomes.*

☐non-drug therapies (list all): _____

☐drug therapies (specify):

- ☐acetaminophen
- ☐intra-articular corticosteroid injections
- ☐NSAIDs
- ☐other: _____

RENEWAL requests

Did the requested agent improve the member's condition and level of functioning?	☐ Yes – *Submit clinical documentation of member's response to the requested agent.* ☐ No

Record dates all previous Intra-Articular Hyaluronate injections. *SUBMIT CHART DOCUMENTATION of product used and dates of injections*.

☐ right knee	date: _____	date: _____	date: _____	date: _____
☐ left knee	date: _____	date: _____	date: _____	date: _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber 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.)