Clinical Policy: Intra-Articular Hyaluronates

Reference Number: PHW.PDL.696
Effective Date: 01/01/2020
Last Review Date: 06/2026

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of PA Health & Wellness® that Intra-Articular Hyaluronates are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Intra-Articular Hyaluronates

A. Prescriptions That Require Prior Authorization

All prescriptions for Intra-Articular Hyaluronates must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Intra-Articular Hyaluronate, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. Is prescribed the Intra-Articular Hyaluronate for the treatment of a diagnosis that is consistent with the U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

2. Has a documented history of therapeutic failure, contraindication, or intolerance to **all** of the following:

   a. Non-pharmacologic treatments,
   b. Acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs),
   c. Intra-articular glucocorticoid injection;

   AND

3. Does not have a contraindication to the requested agent; **AND**

4. For a non-preferred Intra-Articular Hyaluronate, has a documented history of therapeutic failure, contraindication, or intolerance of the preferred Intra-Articular Hyaluronates; **AND**

5. If a prescription for an Intra-Articular Hyaluronate is for a quantity that exceeds the

quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR AN INTRA-ARTICULAR HYALURONATE: The determination of medical necessity of a request for renewal of a prior authorization for an Intra-Articular Hyaluronate that was previously approved will take into account whether the member:

1. Has documented improvement in pain or joint function following the most recenttreatment; **AND**

2. Did not receive an Intra-Articular Hyaluronate in the same joint within the past 6 months; **AND**

3. Does not have a contraindication to the requested agent; **AND**

4. For a non-preferred Intra-Articular Hyaluronate, has a history of therapeutic failure of or a contraindication or an intolerance of the preferred Intra-Articular Hyaluronates;

5. If a prescription for an Intra-Articular Hyaluronate is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

   NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

B. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Intra-Articular Hyaluronate. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member.

C. Dose and Duration of Therapy

Requests for prior authorization of Intra-Articular Hyaluronates will be approved for one treatment course per knee.

D. References

1. Kolasinski SL, et.al. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Management of Osteoarthritis of the Hand, Hip, and Knee. Arthritis Care Res (Hoboken). 2020 Feb;72(2):149-162.Recommendations for the Use of Nonpharmacologic and Pharmacologic Therapies in Osteoarthritis of the Hand, Hip, and Knee. Arthritis Care & Research. 64(4), April 2012, 465–474.
2. Fernandes, L. et.al, EULAR recommendations for the non-pharmacological core management of hip and knee osteoarthritis. Ann Rheum Dis doi:10.1136/annrheumdis-2012-202745 Published Online First 17 April 2013.
3. Jordan, K.M. et.al, EULAR Recommendations 2003: an evidence based approach to the management of knee osteoarthritis: Report of a Task Force of the Standing Committee for International Clinical Studies Including Therapeutic Trials (ESCISIT) Ann Rheum Dis, Publish Online First: 21 July 2003; 62: 1145 - 1155.
4. McAlindon, T.E. et.al, OARSI guidelines for the non-surgical management of knee osteoarthritis. Osteoarthritis and Cartilage 22 (2014) 363e388.
5. American Academy of Orthopaedic Surgeons Management of Osteoarthritis of the Hip Evidence-Based Clinical Practice Guideline. aaos.org/oahcpg2 Published 12/01/2023.
6. American Academy of Orthopaedic Surgeons Management of Osteoarthritis of the Knee (Non-Arthroplasty) Evidence-Based Clinical Practice Guideline. https://www.aaos.org/oak3cpg Published 08/31/2021.
7. Deveza, L.A. et.al. Management of knee osteoarthritis. UpToDate accessed 4/2/2026.
8. Deveza, L.A. et.al. Overview of the management of osteoarthritis UpToDate accessed 4/2/2026.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021: policy revised according to DHS revisions effective 01/05/2021	11/2020
Q1 2022 annual review: no changes.	10/2021
Q1 2023 annual review: no changes.	11/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: no changes.	11/2024
Q1 2026 annual review: no changes.	11/2025
Q3 2026: policy revised according to DHS revisions effective 07/06/2026.	07/2026