Viscosupplementation Injectable Medication Precertification Request

(Please complete all fields and return for precertification requests.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: ☐ Start of treatment ☐ Continuation of therapy: ☐ Right knee ☐ Left knee ☐ both knees **Today's date:** ____________

Date of last treatment: ____________ **Date needed:** ____________

If ASRx is dispensing, ship to: ☐ Doctor's office ☐ Patient ☐ Other: ____________ Phone: ____________

Dispensing Provider: ☐ Aetna Specialty Pharmacy® or ☐ Other: ____________

Phone: ____________ Fax: ____________ **TIN:** ____________ PIN: ____________

Requesting medication administration code? ☐ Yes ☐ No If yes, **CPT Code:** ☐ 20610 ☐ Other: ____________

Precertification Requested By: ____________ Phone: ____________ Fax: ____________

A. PATIENT INFORMATION

First Name: | Last Name:
Address: | City: | State: | ZIP:
Home Phone: | Work Phone: | Cell Phone:
DOB: | Allergies: | Email:
Patient Current Weight: ________ lbs or ________ kgs Patient Height: ________ inches or ________ cms

B. INSURANCE INFORMATION

Aetna Member ID #: ____________
Group #: ____________
Insured: ____________

Does patient have other coverage? ☐ Yes ☐ No
If Yes, provide ID#: ____________ Carrier Name: ____________
Insured: ____________

Medicare: ☐ Yes ☐ No If Yes, provide ID #: ____________ **Medicaid**: ☐ Yes ☐ No If Yes, provide ID #: ____________

C. PRESCRIBER INFORMATION

First Name: | Last Name: | *(Circle one)*: M.D. D.O. N.P. P.A.
Address: | City: | State: | ZIP:
Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN:
Provider Email: | Office Contact Name: | Phone:

Specialty *(Check one)*: ☐ **Orthopedic** ☐ **Primary Provider** ☐ **Other**: ____________

D. DIAGNOSIS INFORMATION - Please indicate primary ICD-9 code and specify any other any other if applicable .

Primary ICD-9: ☐ ____________ ☐ Other ICD-9 Code: ____________

E. CLINICAL INFORMATION - All clinical questions must be completed for precertification request.

Requesting prior authorization for viscosupplementation therapy for: ☐ **Right knee** ☐ **Left knee** ☐ **both knees**

Please indicate which drug you are requesting*: (**P** is preferred, **NP** is non-preferred)*

☐ **Euflexxa® (P)** ☐ **Hyalgan® (NP)** ☐ **Orthovisc® (P)** ☐ **Supartz® (NP)** ☐ **Synvisc® (NP)** ☐ **Synvisc One® (NP)**

☐ Yes ☐ No Does the patient have symptomatic osteoarthritis of the knee?
If Yes, has this been documented in the patient's medical record? ☐ **Yes** ☐ **No**

☐ Yes ☐ No Has the patient had a documented failure after at least 3 months of conservative therapy (including physical therapy, pharmacotherapy, i.e. non steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, and/or topical capsaicin cream) or unable to tolerate conservative therapy because of adverse side effects?

☐ Yes ☐ No Has the patient failed to adequately respond to aspiration and injection of intra-articular steroids?

☐ Yes ☐ No Does the patient report pain which interferes with functional activities (i.e., ambulation, prolonged standing)?
If Yes, is the pain attributed to other forms of joint disease? ☐ **Yes** ☐ **No**

☐ Yes ☐ No Does the patient have any contraindications to the injections (i.e., active joint infection, bleeding disorder)?

☐ Yes ☐ No Does the patient have a contraindication to Euflexxa and Orthovisc?
If Yes, please explain: ____________

If requesting additional series of injections for patient: Date of last injection from prior series: ___/___/___

☐ Yes ☐ No Did the patient respond adequately to the prior series of injections?

☐ Yes ☐ No Does the patient's medical record demonstrate a reduction in the dose of NSAIDs (or other analgesics or anti-inflammatory medication) during the period following the previous series of injections?

☐ Yes ☐ No Does the patient's medical record document significant improvement in pain and functional capacity as the result of the previous injections?

F. PRESCRIPTION – To be completed for precertification request. Prescriptions will be forwarded to Aetna Specialty Pharmacy unless otherwise noted.

MEDICATION - Refer to CPB # 0179	ASRx DISPENSING?	DIRECTIONS	QUANTITY
☐ **Euflexxa** (sodium hyaluronate 1%)	☐ Yes ☐ No		
☐ **Hyalgan** (sodium hyaluronate)			
☐ **Orthovisc** (high molecular weight form of hyaluronic acid)			
☐ **Supartz** (sodium hyaluronate)			
☐ **Synvisc** (hylan G-F 20)			
☐ **Synvisc One** (hylan G-F 20)			

***If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.**
***If the prescriber is providing the drug, the provider must verify benefits.**

Prescriber's Signature: ____________ **Date:** ___/___/___

(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)

Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY" in this space: ____________

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.