Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Sodium Hyaluronate– Medical Necessity Request

(Euflexxa, Synvisc, Synvisc One, Hyalgan, Supartz, Orthovisc, Monovisc, Hymovis, GelSyn-3, Genvisc 850, Synojoynt)

1. Has the member tried and failed a topical NSAID? **Yes or NO**
   - If No, can the member try a topical NSAID instead of sodium hyaluronate? **Yes or No**
     - If yes, please call the prescription in to the pharmacy.
     - If No, please provide the clinical reason(s) why member cannot try a topical NSAID. ____

       _____

2. Has the member tried and failed acetaminophen (Tylenol) or an NSAID (drugs such as ibuprofen, naproxen, meloxicam, etc)? **Yes or No**
   - If No, can the member try oral acetaminophen or an oral NSAID instead of sodium hyaluronate? **Yes or No**
     - If yes, please call the prescription in to the pharmacy.
     - If No, please provide the clinical reason(s) why member cannot try acetaminophen or an NSAID.

       ____

       _____

3. What is the diagnosis?
   - □ Osteoarthritis of the knee
     - Which knee(s) is/are affected? _____
   - □ DJD (Degenerative Joint Disease) of the knee
     - Which knee(s) is/are affected? _____
   - □ Other: _____

4. Which of the following conservative, non-pharmacologic therapies has the member tried:
   - □ Exercise
   - □ Strength training
   - □ Physical therapy
   - □ Assistive devices
   - □ Self-management programs
   - □ Weight loss
     - Current weight: _____ lbs or kg
     - Height: _____ft/in or cm
   - □ NONE
     - Can the member try a conservative, non-pharmacologic therapy instead? **Yes or No**
       - If no, please provide the reason why member cannot try a conservative, non-pharmacologic therapy.

       _____

       _____

5. Has the member tried and failed intra-articular corticosteroids?
   - □ Yes
   - □ No – Can the member try an intra-articular corticosteroid? **Yes or No**
     - If no, please provide the reason why the member cannot try an intra-articular corticosteroid?

   _____

   _____

6. What specialty is managing the member?
   - □ Rheumatology
   - □ Orthopedics
   - □ Physiatry (Physical Medicine & Rehabilitation)
   - □ Pain Management
   - □ Sports Medicine
   - □ Other: _____

Physician office's signature*_____ Print Name_____

*** Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

7. Does the member have infections or skin diseases in the area of the injection site or joint? **Yes or No**

8. Has the member received sodium hyaluronate within the immediate past 6 months in the requested knee(s)? **Yes or No**
   - If Yes, please provide the clinical reason why the member is receiving this medication more frequently than every 6 months. _____

8. For Monovisc requests, does the member have a known systemic bleeding disorder? **Yes or No**

Physician office's signature*_____ Print Name_____
*** Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Sodium Hyaluronate– Medical Necessity Request

(Euflexxa, Synvisc, Synvisc One, Hyalgan, Supartz, Orthovisc, Monovisc, Hymovis, GelSyn-3, Genvisc 850, Synojoynt)

*****Complete page 3 only for Subsequent/Renewal Requests*****

1. What is the diagnosis?
   - □ Osteoarthritis of the knee
     - Which knee(s) is/are affected? _____
   - □ DJD (Degenerative Joint Disease) of the knee
     - Which knee(s) is/are affected? _____
     - □ Other: _____

2. Has the member experienced significant improvement from prior course of therapy, defined as one of the following?
   a. Lower pain score from baseline **Yes or No**
   b. Improvement in ambulation or quality of daily living **Yes or No**
   c. Reduction in the use of analgesics **Yes or No**

3. Has the member received sodium hyaluronate within the immediate past 6 months in the requested knee(s)? **Yes or No**
   - If Yes, please provide the clinical reason why the member is receiving this medication more frequently than every 6 months.

     _____

Physician office's signature*_____ Print Name_____

*** Form must be completed and signed by physician or licensed representative from the physician's office**