



# MEDICARE FORM

## Viscosupplementation Injectable Medication Precertification Request

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(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:  
For other lines of business:  
Please use commercial form.

Note: Single injection: Gel-One and Monovisc are non-preferred. Durolane and Synvisc-One are preferred. Multi-injection: Gelsyn-3, GenVisc, Hyalgan, Hymovis, Orthovisc, Supartz FX, Trivisc, and Visco-3 are non-preferred. Euflexxa and Synvisc are preferred. The preferred products do not require precertification.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to:

**Phone:** [1-866-503-0857](tel:1-866-503-0857) (TTY: [711](tel:1-866-503-0857))

**Fax:** [1-844-268-7263](tel:1-844-268-7263)

**Availity:** <https://www.aetna.com/health-care-professionals/resource-center/availability.html>

For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:

**Phone:** [1-855-463-0933](tel:1-855-463-0933)

**Fax:** [1-833-280-5224](tel:1-833-280-5224)

**Availity:** <https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal>

For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:

**Phone:** [1-844-362-0934](tel:1-844-362-0934)

**Fax:** [1-833-322-0034](tel:1-833-322-0034)

**Availity:** <https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html>

For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to:

**Phone:** [1-866-600-2139](tel:1-866-600-2139)

**FAX:** [1-855-320-8445](tel:1-855-320-8445)

**Availity:** <https://www.aetnabetterhealth.com/illinois/providers/portal>

For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to:

**Phone:** [1-855-364-0974](tel:1-855-364-0974)

**Fax:** [1-855-734-9389](tel:1-855-734-9389)

**Availity:** <https://www.aetnabetterhealth.com/ohio/providers/portal>

For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to:

**Phone:** [1-855-676-5772](tel:1-855-676-5772)

**Fax:** [1-844-241-2495](tel:1-844-241-2495)

**Availity:** <https://www.aetnabetterhealth.com/michigan/providers/portal.html>



# MEDICARE FORM

## Viscosupplementation Injectable

### Medication Precertification Request

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(All fields must be completed and legible for precertification review.)

**For Medicare Advantage Part B:**  
**For other lines of business:**  
 Please use commercial form.

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**Please indicate:**  Start of treatment: Start date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Continuation of therapy (Request Additional Series Below)

**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:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms		

#### B. INSURANCE INFORMATION

Aetna Member ID #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Group #:	If yes, provide ID#:		Carrier Name:	
Insured:	Insured:			

#### C. PRESCRIBER INFORMATION

First Name:		Last Name:			<i>(Check One):</i> <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.		
Address:		City:	State:	ZIP:			
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:		
Provider Email:		Office Contact Name:		Phone:			

#### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b>				<b>Dispensing Provider/Pharmacy:</b>			
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <input type="checkbox"/> Outpatient Infusion Center Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____				<input type="checkbox"/> Outpatient Dialysis Center <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____			

#### E. PRODUCT INFORMATION

**Request is for: *No precertification required***

Durolane (hyaluronic acid)  Synvisc-One (hylan G-F 20)  Euflexxa (1% sodium hyaluronate)  Synvisc (hylan G-F 20)

***Precertification required***

Gel-One (cross-linked hyaluronate)  Gelsyn-3 (sodium hyaluronate)  GenVisc 850 (sodium hyaluronate)  Hyalgan (sodium hyaluronate)  
 Supartz FX (sodium hyaluronate)  Hymovis (high molecular weight viscoelastic hyaluronan)  Orthovisc (high molecular weight hyaluronan)  
 Monovisc (sodium hyaluronate)  TriVisc (sodium hyaluronate)  Visco-3 (sodium hyaluronate)  Synjoyn (1% sodium hyaluronate)  
 Triluron (1% sodium hyaluronate)

**Dose:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_ **HCPCS Code:** \_\_\_\_\_

#### F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

**Primary ICD Code:** \_\_\_\_\_ **Secondary ICD Code:** \_\_\_\_\_ **Other ICD Code:** \_\_\_\_\_

#### G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

**For Initiation Requests (clinical documentation required for all requests):**

**Note:** Single injection products: Gel-One and Monovisc are non-preferred. The preferred products are Durolane and Synvisc-One. The preferred products do not require precertification.

**Multi injection products:** Gelsyn-3, GenVisc, Hyalgan, Hymovis, Orthovisc, Supartz FX, TriVisc and Visco-3 are non-preferred. The preferred products are Euflexxa and Synvisc. The preferred products do not require precertification.

Yes  No Has the patient had prior therapy with the requested viscosupplementation product within the last 365 days?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION (continued)** – Required clinical information must be completed in its entirety for all precertification requests.

**For Initiation Requests continued (clinical documentation required for all requests):**

- No Has the patient had an adverse reaction to any of the following? (if yes, select all that apply below)
  - Durolane  Synvisc-One
  - When was the member's adverse reaction to the preferred drug? \_\_\_\_\_
  - Please describe the nature of the adverse reaction to the preferred drug \_\_\_\_\_
- No Has the patient had an adverse reaction to any of the following? (if yes, select all that apply below)
  - Euflexxa  Synvisc
  - When was the member's adverse reaction to the preferred drug? \_\_\_\_\_
  - Please describe the nature of the adverse reaction to the preferred drug \_\_\_\_\_

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following (select all that apply)

- Durolane  Synvisc-One

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following (select all that apply)

- Euflexxa  Synvisc

**For All Requests (includes Medicare patient requests, clinical documentation required for all requests):**

- Yes  No Does the patient have documented symptomatic osteoarthritis (OA) of the tibiofemoral articulation of the knee?
  - Which knee will the viscosupplement be used?  Left knee  Right knee  Both knees
- Yes  No Is there radiologic evidence of osteoarthritis (OA) of the knee?
  - Yes  No Is the patient symptomatic?
    - Which of the following documented symptoms of osteoarthritis (OA) does the patient have? (Check ALL that apply)
      - Knee Pain  Bony enlargement  Bony tenderness  Crepitus (noisy, grating sound) on active motion
      - Erythrocyte sedimentation rate (ESR) less than 40 mm/hr  Less than 30 minutes of morning stiffness
      - No palpable warmth of synovium  Over 50 years of age
      - Rheumatoid factor less than 1:40 titer (agglutination method)
      - Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3)
    - Which of the following radiologic findings support the clinical diagnosis of osteoarthritis (OA)?
      - Please select:  Joint space narrowing  Subchondral sclerosis  Osteophytes and sub-chondral cysts
- Yes  No Does the patient have knee pain that interferes with functional activities (e.g. ambulation or prolonged standing)?
- Yes  No Can the knee pain be attributed to any other forms of joint disease (other than osteoarthritis)?
- Yes  No Has the patient completed conservative therapy in each joint to be treated with viscosupplementation?
  - Yes  No Is the patient unable to tolerate conservative therapy because of adverse side effects?
    - Please indicate which of the following conservative therapies the patient completed:
      - Physical therapy  Acetaminophen  Topical capsaicin cream  NSAID's, Specify: \_\_\_\_\_
      - Other: please explain: \_\_\_\_\_
- Yes  No Has the conservative treatment resulted in functional improvement after therapy?
- Yes  No Has the patient failed to adequately respond to aspiration and injection of intra-articular steroids?
- Yes  No Are there any contraindications to the patient receiving viscosupplementation injections (e.g. active joint infection, bleeding disorder or skin infections at the injection site)?
- Yes  No Is the patient scheduled to undergo a total knee replacement within 6 months of starting viscosupplementation treatment?
- Yes  No Will the drug requested be used concomitantly with any of the following?
  - Please select:  With intra-articular anesthetics  With intra-articular corticosteroids  With intra-articular platelet rich plasma
  - With intra-articular mannitol/sorbitol  With intra-articular mesenchymal stem cells  With another viscosupplement
- Yes  No Does the patient have morning stiffness of less than 30 minutes in duration?
- Yes  No Does the patient have crepitus on motion of the knee?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION (continued)** – Required clinical information must be completed in its entirety for all precertification requests.

**For All Additional Series Requests continued (clinical documentation required for all requests):**

What product did the patient last receive? \_\_\_\_\_

Enter date of last injection from prior series: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Yes  No Have at least six months elapsed since the last injection in the prior series?

Yes  No Has the patient had a documented reduction in the dose of NSAID's, other anti-inflammatories, or other analgesics during the 6-month period following the previous injection series?

    ↳  Yes  No Does the patient require NSAID's, other anti-inflammatories, or other analgesics for a comorbid medical condition in addition to OA of the knee? **If yes**, please identify the comorbid medical condition: \_\_\_\_\_

Yes  No  N/A Was there a reduction in the number of intra-articular steroid injections or aspirations during the 6-month period following the series?

Yes  No Is there objective documentation to support significant improvement of functional capacity as a result of previous injection series?

Yes  No Is there objective documentation to support significant improvement in pain as a result of previous injections?

**H. ACKNOWLEDGEMENT**

**Request Completed By (Signature Required):** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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.

The plan may request additional information or clarification, if needed, to evaluate requests.