pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

INTRA-ARTICULAR HYALURONATES PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Intra-Articular Hyaluronates** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐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:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary 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):

INITIAL requests

Does the beneficiary have a history of trial and failure, contraindication, or intolerance of 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 treatment (list all): _____

_____

☐medications (specify): ☐acetaminophen ☐NSAIDs ☐intra-articular corticosteroid injections ☐other: _____

_____

***Requests for a non-preferred agent*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of 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

RENEWAL requests

Did the requested agent improve the beneficiary's condition and level of functioning?	☐Yes – *Submit clinical documentation of beneficiary'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 DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: