

Osteoarthritis

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. Which drug is being prescribed?
 Euflexxa Hyalgan Orthovisc Supartz Synvisc Synvisc One Other _____
2. Indicate prescribed: Dose: _____ Frequency: _____
3. What is the diagnosis?
 Osteoarthritis of the knee Osteoarthritis of the hip Other _____
4. Has the osteoarthritis been confirmed by X-ray? Yes No
5. Has the patient received a previous course of treatment with viscosupplementation?
**If Yes, skip to # 17* Yes No
6. Does the patient have persistent pain which interferes with functional activities? Yes No
7. Has the patient had a trial of both nonsteroidal anti-inflammatory drug (NSAID) **AND** acetaminophen (APAP) for at least 3 months? Yes No **If No, skip to # 11*
8. Did the patient use prescription strength NSAID and have NSAID dosage increased to maximum approved dosage? Yes No
9. Has the patient had an improvement in functional activities? Yes No
10. Was the patient adherent to prescribed therapies? **If Yes, skip to # 15* Yes No
11. Does the patient have any contraindication to the use of NSAID or APAP (e.g., previous documented history of complicated GI events, age greater than 65, use of anticoagulants, or congestive heart failure)? **If Yes, skip to # 15* Yes No
12. Did the patient have gastrointestinal intolerance (dyspepsia) to NSAID therapy?
 Yes No **If No, skip to # 14*
13. Has the patient tried and had an inadequate response to at least one enteric-coated NSAID formulation?
**If Yes, skip to # 15* Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

14. Was the patient unable to tolerate NSAID or APAP due to other adverse reaction (e.g., rash or allergic reaction, increase in blood pressure, edema)? Yes No
15. Has the patient had an intra-articular steroid injection? Yes No
16. Did intra-articular steroid injection result in unsatisfactory relief of pain or relief lasts less than 3 months? Yes No

Only answer following questions if patient has previously received viscosupplementation.

17. Has the patient received a total of 2 treatment courses with viscosupplementation injection?
 Yes No
18. Has the patient had significant complications (e.g., infection, allergic reaction) occur during the previous treatment cycle? Yes No
19. How many months have elapsed since the last viscosupplementation injection? _____ **months**
20. Has the initial course of treatment resulted in clinically significant improvements in functional capacity and/or symptom relief for at least six months? Yes No

****NOTE: We can NOT make a decision without a copy of the labs - Thank You****

Information given on this form is accurate as of this date:

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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