



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/chp-forproviders/pharmacy

Hyaluronic Acid Derivatives Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information									
Member Name (first & last):			Date of Birth:		Gender:			Height:	
					<input type="checkbox"/> Male	<input type="checkbox"/> Female			
Member ID:			City:		State:			Weight:	
Prescribing Provider Information									
Provider Name (first & last):			Specialty:		NPI#			DEA#	
Office Address:			City:		State:			Zip Code:	
Office Contact:				Office Phone			Office Fax:		
Dispensing Pharmacy Information									
Pharmacy Name:				Pharmacy Phone:			Pharmacy Fax:		
Requested Medication Information									
Preferred Agents:			<input type="checkbox"/> Gel-One		<input type="checkbox"/> Visco-3				
Medication request is NOT for an FDA approved, or compendia supported diagnosis (circle one): Yes No				ICD-10 Code:			Diagnosis:		
What medication(s) have been tried and failed for diagnosis?									
Are there any contraindications to formulary medications? If yes, please specify:					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy request	
Continuation of therapy request ONLY:	Have SIX months elapsed since previous TX?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documentation to support improved response to previous series? (Dose reduction with NSAIDs OR other analgesics)				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Directions for Use:			Strength:			Dosage Form:			
			Quantity:	Day Supply:		Duration of Therapy/Use:			
Turn-Around Time for Review									
<input type="checkbox"/> Standard – (24 hours)				<input type="checkbox"/> Urgent – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____					
Clinical Information									
Was there inadequate response, intolerable side effect, or contraindication to non-pharmacologic therapy (for example, physical therapy, land based or aquatic based exercise, resistance training, or weight loss)?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was there inadequate response, intolerable side effect, or contraindication to trial of pharmacologic therapy , one of which must be oral or topical NSAIDs?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was there inadequate response, intolerable side effect, or contraindication to intra-articular steroid injections?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does the pain interfere with functional activities (for example, ambulation, or prolonged standing)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the pain attributed to other forms of joint disease?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Did member have surgery on the same knee in the past 6 months?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Treatment request is due to any of the following indications?				<input type="checkbox"/> Temporomandibular joint disorders					
				<input type="checkbox"/> Chondromalacia of patella (chondromalacia patellae)					
				<input type="checkbox"/> Pain in joint, lower leg (patellofemoral syndrome)					
				<input type="checkbox"/> Osteoarthritis and allied disorders (joints other than knee)					
				<input type="checkbox"/> Diagnosis of osteoarthritis of hip, hand, shoulder, etc.					

Does member have documentation of radiographic evidence of mild to moderate osteoarthritis of knee? (for example, severe joint space narrowing, subchondral sclerosis, osteophytes)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Member has documentation of symptomatic OA of knee according to ACR clinical AND laboratory criteria, which requires knee pain AND at least FIVE of the following?	<input type="checkbox"/> Bony enlargement <input type="checkbox"/> Bony tenderness <input type="checkbox"/> Crepitus (noisy, grating sound) on active motion <input type="checkbox"/> ESR <40 mm/hour <input type="checkbox"/> < 30 minutes of morning stiffness <input type="checkbox"/> No palpable warmth of synovium <input type="checkbox"/> Rheumatoid factor <1:40 titer (agglutination method) <input type="checkbox"/> Synovial fluid signs (clear fluid of normal viscosity AND white blood cells <2000/mm ³)
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Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____	Date: _____
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Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 833-711-0776 to check the status of a request.