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Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Hyalgan™, Supartz™, Orthovisc®
(Hyaluronate Sodium)

Therapeutic use: Viscosupplements are used in the treatment of osteoarthritis of the knee. Synvisc®, Synvisc®-One and Euflexxa® are the preferred viscosupplements and do not require preauthorization.

Quantity Limits: Single course of treatment initially. Additional courses may be authorized six month after the start of the previous course with documented evidence of at least one "functional status" category improvement.

Authorization Period: 6 months

Patient's name _____

Patient's ID# ☐☐☐ ☐☐ ☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐ ☐☐ ☐☐☐ ☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐)☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Medication Requested: Hyalgan ❑ Supartz ❑ Orthovisc ❑

Knee Joint: Left ❑ Right ❑ Note: Bilateral therapy is not covered

Please check "Yes" or "No" or answer the following questions:			
1.	Is the prescribing physician an orthopedist or rheumatologist? If no, name of consulting orthopedist/rheumatologist? _____ Date of consultation (within the last 3 months): _____	❑ Yes	❑ No
2.	Does the patient have documented primary *osteoarthrosis deformans* (osteoarthritis) of the knee that has been confirmed radiographically?	❑ Yes	❑ No
3.	Does the treating orthopedist/rheumatologist anticipate a total knee replacement within the next 6 months?	❑ Yes	❑ No
4.	Does the patient have both radiologic (anatomic) grade II or III disease *and* moderate to severe functional impairment (see below) of the knee due to osteoarthritis? ❑ Mild: Discomfort, but rare functional limitation; episodic flares ❑ Moderate: Some functional limitation and reduced mobility; regular flares requiring constant analgesic or NSAID use. ❑ Severe: Poor mobility and near constant pain; frequent perpetual flare requiring treatment.	❑ Yes	❑ No
5.	Has the patient failed *all* of the following more conservative therapies? (please check all that apply) ❑ Weight reduction ❑ Activity modification and/or physical therapy ❑ OTC Analgesics ❑ NSAIDs (one month trial during past three months) ❑ Intra-articular steroid injection (one trial within past six months)	❑ Yes	❑ No
6.	Is the patient between 40 to 65 years of age? Requests for patients outside of listed age range **require chart notes**.	❑ Yes	❑ No
7.	Has the patient failed treatment with one of the preferred viscosupplements (Synvisc, Synvisc-One, or Euflexxa)? If no, explain why? _____	❑ Yes	❑ No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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