# Blue Cross Medicare Plus Blue[SM] PPO and BCN Advantage[SM]
# Medication Authorization Request Form
## Hyaluronic acid intra-articular injections

**Gel-One® (hyaluronate sodium), GenVisc850 (hyaluronate sodium), Hyalgan® (hyaluronate sodium), Hymovis (hyaluronate sodium), Monovisc™ (hyaluronic acid), Orthovisc® (hyaluronate sodium), Synojoynt® (sodium hyaluronate), Synvisc/Synvisc-One® (hylan GF-20), Triluron® (sodium hyaluronate), Trivisc™ ((sodium hyaluronate), Visco-3™ (sodium hyaluronate)**

Blue Cross Blue Shield Blue Care Network of Michigan

The most efficient way to request authorization is to use the NovoLogix® system. To access NovoLogix, visit bcbsm.com/providers and log in to Provider Secured Services. Click the link for Medical Prior Authorization. As an alternative, you can use this form to request authorization. Complete this form and fax to 1-866-392-6465. If you have any questions regarding this process, contact the Pharmacy Clinical Help Desk at 1-800-437-3803.

| PATIENT INFORMATION | PHYSICIAN INFORMATION |
|---|---|
| **Name** | **Name** |
| **ID Number** | **Specialty** |
| **D.O.B.** ☐Male ☐Female | **Address** |
| **Diagnosis (include ICD-10)** | **City /State/Zip** |
| **Drug Name** | **Phone:** ( ) - **Fax:** ( ) - |
| **Dose and Quantity** | **NPI** |
| **Directions** | **Contact Person** |
| **Date of Services** | **Contact Person's Phone / Ext.** |

**STEP 1: DISEASE STATE INFORMATION**

**The following Hyaluronic acid products do not require an authorization prior to use: Durolane®, Supartz FX®, Euflexxa® and Gelsyn-3®. Consider using these products first.**

1. **Initial or Continuation of therapy?** ☐ Initial ☐ Continuation Date of last injection:
2. **What is the patient's primary diagnosis** ☐ Osteoarthritis of the knee ☐ Other. Please list diagnosis:
3. **Has patient tried any non-pharmacologic therapies prior to initiating Hyaluronic Acid Intra Articular Injections**?
   - ☐ **Yes**
   - ☐ **No**
4. **Please select which therapies the patient has tried and failed.**
   - ☐ **Acetaminophen**
   - ☐ **NSAIDS**
   - ☐ **Tramadol**
   - ☐ **Intra-articular corticosteroid injections**
   - ☐ **Others. Please list drug:**
5. **Which drug has the patient tried and failed? (Check all that apply)**
   - ☐ **Durolane®**
   - ☐ **Euflexxa®**
   - ☐ **Gel-syn 3®**
   - ☐ **Supartz FX®**
   - ☐ **Others. Please list drug:**

**Coverage won't be provided if the prescribing physician's signature and date aren't reflected on this document.**

☐ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

**Physician's Name** **Physician Signature** **Date**

| | | |
|---|---|---|
| **Step 2:** Checklist | ☐ Form Completely Filled Out<br>☐ Attached Chart Notes | ☐ Concurrent Medical Problems<br>☐ Prior Therapies |
| **Step 3:** Submit | **Fax the completed form to 1-866-392-6465** | |