



Viscosupplementation Injectable Medication Precertification Request

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: Start of treatment Continuation of therapy: Right knee Left knee both knees **Today's date:** _____
Date of last treatment: _____ **Date needed:** _____

Ship to: Doctor's office Patient Other: _____ Phone: _____

Dispensing Provider: Aetna Specialty Pharmacy® or Other: _____
Phone: _____ Fax: _____ **TIN:** _____ **PIN:** _____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION			
First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:		Work Phone:	Cell Phone:
DOB:	Allergies:		Email:
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION	
Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If Yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide ID #: _____

C. PRESCRIBER INFORMATION			
First Name:		Last Name: (Circle one): M.D. D.O. N.P. P.A.	
Address:		City:	State: ZIP:
Phone:	Fax:	St Lic #:	NPI #: DEA #: UPIN:
Provider Email:		Office Contact Name: Phone:	

Specialty (Check one): Orthopedic Primary Provider Other: _____

D. DIAGNOSIS INFORMATION - Please indicate primary ICD-9 code and specify any other any other where applicable (*).	
Primary ICD-9: <input type="checkbox"/> _____	<input type="checkbox"/> Other ICD-9 Code: _____

E. CLINICAL INFORMATION - All clinical questions must be completed for precertification request.	
Requesting prior authorization for viscosupplementation therapy for: <input type="checkbox"/> Right knee <input type="checkbox"/> Left knee <input type="checkbox"/> both knees	
Please indicate which drug you are requesting: (P is preferred, NP is non-preferred)	
<input type="checkbox"/> Euflexxa® (P) <input type="checkbox"/> Hyalgan® (NP) <input type="checkbox"/> Orthovisc® (P) <input type="checkbox"/> Supartz® (NP) <input type="checkbox"/> Synvisc® (NP) <input type="checkbox"/> Synvisc One® (NP)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have documented symptomatic osteoarthritis of the knee?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a documented failure after at least 3 months of conservative therapy (including physical therapy, pharmacotherapy, i.e. non steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, and/or topical capsaicin cream)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient unable to tolerate conservative therapy because of adverse side effects?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient failed to adequately respond to aspiration and injection of intra-articular steroids?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient report pain which interferes with functional activities (i.e., ambulation, prolonged standing)?
	If Yes, is the pain attributed to other forms of joint disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have any contraindications to the injections (i.e., active joint infection, bleeding disorder)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a documented trial and failure of Euflexxa and Orthovisc?
	If Yes, please provide the dates of treatment for both products: Euflexxa: _____ Orthovisc: _____
	If requesting additional series of injections for patient: Date of last injection from prior series: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the patient respond adequately to the prior series of injections?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient's medical record demonstrate a reduction in the dose of NSAIDs (or other analgesics or anti-inflammatory medication) during the period following the previous series of injections?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient's medical record document significant improvement in pain and functional capacity as the result of the previous injections?

F. PRESCRIPTION - To be completed for precertification request. Prescriptions will be forwarded to Aetna Specialty Pharmacy unless otherwise noted.			
MEDICATION - Refer to CPB # 0179	ASRx DISPENSING?	DIRECTIONS	QUANTITY
<input type="checkbox"/> Euflexxa (sodium hyaluronate 1%)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Hyalgan (sodium hyaluronate)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Orthovisc (high molecular weight form of hyaluronic acid)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Supartz (sodium hyaluronate)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Synvisc (hylan G-F 20)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Synvisc One (hylan G-F 20)	<input type="checkbox"/> Yes <input type="checkbox"/> No		

*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.
*If the prescriber is providing the drug, the provider must verify benefits.

Prescriber's Signature: _____ **Date:** ____/____/____
(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)

Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY" in this space: _____