



Prior Authorization Request Form for Intra-Articular Hyaluronates

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at <https://www.covermyeds.com/main/prior-authorization-forms/>

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Prescriber Name:	Member Name:		
Prescriber Specialty:	Identification #:		
NPI:	Group #:		
Office Contact Name:	Date of Birth:		
Fax #:	Medication Allergies:		
Phone #:			
III. DRUG INFORMATION (One drug request per form)			
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:	
Joint to be injected:	Dosage Form (vial, syringe):		
IV. REQUIRED DOCUMENTATION <i>(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)</i>			
Specify diagnosis & diagnosis code relevant to this request:		Dx/Dx Code: _____	
Does the member have a history of contraindication to the prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Intra-Articular Hyaluronate? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.	<input type="checkbox"/> Yes <i>Medications Taken (start and end date and dose):</i> _____ _____ <input type="checkbox"/> No _____ _____		
<input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to https://www.pahealthwellness.com/providers/pharmacy.html under PHW Quantity Limit List), please provide supporting information: _____			
SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.			
INITIAL REQUESTS:			
<input type="checkbox"/> Documented history of therapeutic failure, contraindication or intolerance to ALL of the following: (medication, start date and end date)			
<input type="checkbox"/> Non-pharmacologic treatment: _____			
<input type="checkbox"/> Acetaminophen or Non-steroidal anti-inflammatory drug (NSAIDs): _____			
<input type="checkbox"/> Intra-articular glucocorticoid injection: _____			
RENEWAL REQUESTS:			
<input type="checkbox"/> Documentation improvement in pain or joint function following the first treatment: _____			
<input type="checkbox"/> Member has not received an Intra-Articular Hyaluronate in the same joint within the past 6 months			
<input type="checkbox"/> Date of last injection: _____			
IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :			

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Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:
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Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)