Horizon NJ Health

Sodium Hyaluronate – Medical Necessity Request
(Euflexxa, Synvisc, Synvisc One, Hyalgan, Supartz, Orthovisc, Monovisc, Hymovis, GelSyn-3, Genvisc 850, Synojoynt)

1. Has the member tried and failed acetaminophen (Tylenol) or an NSAID (drugs such as ibuprofen, naproxen, meloxicam, etc)?
   Yes or No
   - If No, can the member try acetaminophen or an NSAID instead of sodium hyaluronate? Yes or No
   - If yes, please call the prescription in to the pharmacy.
   - If No, please provide the clinical reason(s) why member cannot try acetaminophen or an NSAID.

2. What is the diagnosis?
   □ Osteoarthritis of the knee
   - Which knee(s) is/are affected? ____________
   □ DJD (Degenerative Joint Disease) of the knee
   - Which knee(s) is/are affected? ____________
   □ Other: ________________________________

3. Which of the following conservative, non-pharmacologic therapies has the member tried:
   □ Exercise
   □ Strength training
   □ Physical therapy
   □ Weight loss
     - Current weight: _____ lbs or kg
     - Height: _____ ft/in or cm
   □ NONE
   - Can the member try a conservative, non-pharmacologic therapy instead? Yes or No
     - If no, please provide the reason why member cannot try a conservative, non-pharmacologic therapy.

4. Has the member tried and failed intra-articular corticosteroids?
   □ Yes
   □ No – Can the member try an intra-articular corticosteroid? Yes or No
     - If no, please provide the reason why the member cannot try an intra-articular corticosteroid.

5. What specialty is managing the member?
   □ Rheumatology
   □ Orthopedics
   □ Physiatry (Physical Medicine & Rehabilitation)
   □ Pain Management
   □ Sports Medicine
   □ Other: ________________________________

6. Does the member have infections or skin diseases in the area of the injection site or joint? Yes or No

7. Has the member received sodium hyaluronate within the immediate past 6 months in the requested knee(s)? Yes or No
   - If Yes, please provide the clinical reason why the member is receiving this medication more frequently than every 6 months.

8. For Monovisc requests, does the member have a known systemic bleeding disorder? Yes or No

Physician office’s signature* _________________ Print Name _______________________________________________
* Form must be completed and signed by physician or licensed representative from the physician’s office
**Complete page 2 only for Subsequent/Renewal Requests**

1. What is the diagnosis?
   - □ Osteoarthritis of the knee
     - Which knee(s) is/are affected? ____________
   - □ DJD (Degenerative Joint Disease) of the knee
     - Which knee(s) is/are affected? ____________
   - □ Other: ________________________________

2. Has the member experienced significant improvement from prior course of therapy, defined as one of the following?
   a. Lower pain score from baseline  **Yes or No**
   b. Improvement in ambulation or quality of daily living  **Yes or No**
   c. Reduction in the use of analgesics  **Yes or No**

3. Has the member received sodium hyaluronate within the immediate past 6 months in the requested knee(s)?  **Yes or No**
   - If Yes, please provide the clinical reason why the member is receiving this medication more frequently than every 6 months.
     _______________________________________________________________________________________

**Form must be completed and signed by physician or licensed representative from the physician’s office**

*Rev. 2/19*