Neighborhood Health Plan OF RHODE ISLAND™

Hyaluronic acid Intraarticular Injections Authorization form

Tel. 401-427-8200; Fax 844-639-7906

Hyaluronic acid Intraarticular Injections: Hyalgan, Euflexxa, Orthovisc, Supartz, Synvisc, Synvisc-One Prior Authorization form (Drugs Administered in Office), fax requests to 844-639-7906

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
Member Phone Number:	Member Address:	Gender: □ Male □Female □Unknown Primary Language: □ English □Spanish □ Other:

REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Date of Request:	Provider's NPI #:	Provider's Contact Name and Phone:

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

❑ Drop Ship from Specialty Pharmacy: _____and NPI_____

❑ If Buy & Bill: Specify Provider/ Facility: _____ and NPI _____

Servicing Provider Fax#: _____

CLINICAL INFORMATION		
Requested J-Code:	Requested CPT code(s):	□ Initial Request □ Continuation of therapy Request
Drug Name& strength:		Date(s) of Service Requested:
Directions:		# of units:
ICD 10 Codes:		

Clinical Assessment (provide all required information and clinical documentation)	YES	NO
Does patient have a diagnosis of moderate to severe osteoarthritis? * *Radiographic report documenting moderate to severe osteoarthritis of the knee(s) must be submitted with request. *	☐	☐
Has the patient failed at least one non-steroidal anti-inflammatory drug (NSAIDs) or at least 2 NSAIDs if reported failures are related to side effects or acetaminophen(if NSAIDS are contraindicated) within the last 12 months at anti-inflammatory doses for at least 6 weeks?	☐	☐
Has the patient failed intra-articular corticosteroid injection to the affected knee lasting less than 6-8 weeks within the last 12 months?* *	☐	☐

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN

Signature of Requesting Provider:	**Date:**

Authorization is not a guarantee of payment. Member must be eligible at time of service.