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Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Hyaluronan Injections
Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Device information

Device requested

☐ Durolane (hyaluronate)
☐ Euflexxa (hyaluronate)
☐ Gel-One (cross-linked hyaluronate)
☐ Gelsyn (hyaluronate)
☐ Genvisc (hyaluronate)
☐ Hyalgan (hyaluronate)
☐ Hymovis (hyaluronate modified)
☐ Monovisc (hyaluronate)
☐ Orthovisc (high molecular weight hyaluronan)
☐ Supartz (hyaluronate)
☐ Synvisc (hylan G-F 20)
☐ Synvisc-One (hylan G-F 20)
☐ Visco-3 (hyaluronate)

Dose, frequency and duration of device requested _____

Indication (check all that apply)

☐ Osteoarthritis of the knee ☐ Left knee ☐ Right knee ☐ Both knees

☐ Other (please indicate) _____

Is the request for retreatment of the same knee(s)? ☐ Yes ☐ No

Section I. Please complete the following for all requests.

1. Please indicate whether the request is for pharmacy or in-office billing. ☐ Pharmacy billing ☐ In-office billing
2. Has the member tried acetaminophen?
   ☐ Yes. Please provide the following information.* Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response
   Briefly describe details of adverse reaction or inadequate response.
   _____
   ☐ No. Does the member have a contraindication to acetaminophen? Please explain.
   _____

3. Has the member tried intra-articular corticosteroid injection?
   ☐ Yes. Please provide the following information.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response

   Briefly describe details of adverse reaction or inadequate response.

   _____

   ☐ No. Does the member have a contraindication to intra-articular corticosteroid injection? Please explain.

   _____

4. Has the member had an adverse reaction or inadequate response to a non-steroidal anti-inflammatory drug (NSAID)?
   ☐ Yes. Please provide the following information.*
   Drug name _____ Dates/duration of use _____
   Briefly describe details of adverse reaction or inadequate response.

   _____

   ☐ No. Does the member have a contraindication to all non-steroidal anti-inflammatory drugs (NSAIDs)? Please explain.

   _____

* *Please attach a letter documenting additional trials as necessary.*

Section II. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____
NPI* _____ Individual MH Provider ID _____
DEA No. _____ Office Contact Name _____
Address _____ City _____ State _____ Zip _____
E-mail address _____
Telephone No.* _____ Fax No.* _____
* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____