MEDICARE FORM
Viscosupplementation Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Single injection: Gel-One and Monovisc are non-preferred. Durolane and Synvisc-One are preferred. Multi-injection:, Gelsyn-3, GenVisc, Hyalgan, Hymovis, Orthovisc, Supartz FX, Trivisc, and Visco-3 are non-preferred. Euflexxa and Synvisc are preferred. The preferred products do not require precertification.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to:
Phone: 1-866-503-0857 **(TTY:** 711**)**
Fax: 1-844-268-7263
Availity: https://www.aetna.com/health-care-professionals/resource-center/availity.html

For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:
Phone: 1-855-463-0933
Fax: 1-833-280-5224
Availity: https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal

For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:
Phone: 1-844-362-0934
Fax: 1-833-322-0034
Availity: https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html

For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to:
Phone: 1-866-600-2139
Fax: 1-855-320-8445
Availity: https://www.aetnabetterhealth.com/illinois/providers/portal

For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to:
Phone: 1-855-364-0974
Fax: 1-855-734-9389
Availity: https://www.aetnabetterhealth.com/ohio/providers/portal

For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to:
Phone: 1-855-676-5772
Fax: 1-844-241-2495
Availity: https://www.aetnabetterhealth.com/michigan/providers/portal.html

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Please indicate: ☐ Start of treatment: Start date ____/____/____ ☐ Continuation of therapy (Request Additional Series Below)

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:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name:		*(Check 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:		

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ *Outpatient Dialysis Center* ☐ Physician's Office
☐ Retail Pharmacy ☐ Specialty Pharmacy
☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: *No precertification required*
☐ Durolane (hyaluronic acid) ☐ Synvisc-One (hylan G-F 20) ☐ Euflexxa (1% sodium hyaluronate) ☐ Synvisc (hylan G-F 20)

Precertification required
☐ Gel-One (cross-linked hyaluronate) ☐ Gelsyn-3 (sodium hyaluronate) ☐ GenVisc 850 (sodium hyaluronate) ☐ Hyalgan (sodium hyaluronate)
☐ Supartz FX (sodium hyaluronate) ☐ Hymovis (high molecular weight viscoelastic hyaluronan) ☐ Orthovisc (high molecular weight hyaluronan)
☐ Monovisc (sodium hyaluronate) ☐ TriVisc (sodium hyaluronate) ☐ Visco-3 (sodium hyaluronate) ☐ Synojoynt (1% sodium hyaluronate)
☐ Triluron (1% sodium hyaluronate)

HCPCS Code: _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

Note: Single injection products: Gel-One and Monovisc are non-preferred. The preferred products are Durolane and Synvisc-One. The preferred products do not require precertification.

Multi injection products: Gelsyn-3, GenVisc, Hyalgan, Hymovis, Orthovisc, Supartz FX, TriVisc and Visco-3 are non-preferred. The preferred products are Euflexxa and Synvisc. The preferred products do not require precertification.

☐ Yes ☐ No Has the patient had prior therapy with the requested viscosupplementation product within the last 365 days?

Continued on next page

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests *continued* (clinical documentation required for all requests):

☐ No Has the patient had an adverse reaction to any of the following? (if yes, select all that apply below)
- ☐ Durolane ☐ Synvisc-One
- When was the member's adverse reaction to the preferred drug? _____
- Please describe the nature of the adverse reaction to the preferred drug _____

☐ No Has the patient had an adverse reaction to any of the following? (if yes, select all that apply below)
- ☐ Euflexxa ☐ Synvisc
- When was the member's adverse reaction to the preferred drug? _____
- Please describe the nature of the adverse reaction to the preferred drug _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following (select all that apply)
☐ Durolane ☐ Synvisc-One

_____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following (select all that apply)
☐ Euflexxa ☐ Synvisc

_____

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Does the patient have osteoarthritis (OA) of the knee?
- Which knee will the viscosupplement be used? ☐ Left knee ☐ Right knee ☐ Both knees

☐ Yes ☐ No Does the patient have osteoarthritis (OA) of the shoulder?
- Which shoulder will the viscosupplement be used? ☐ Left shoulder ☐ Right shoulder ☐ Both shoulders

For All Additional Series Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is this request for a hyaluronate injection in the same joint which has previously received a hyaluronate injection?
- What product did the patient last receive? _____
- Enter date of last injection from prior series: ____/____/____

☐ Yes ☐ No Will the patient receive the first injection of this course after at least 6 months from the last injection of the previous completed course?
☐ Yes ☐ No Was the previous course effective for treating the diagnosis or condition?
☐ Yes ☐ No Is a different hyaluronate product being requested due to an adverse event with the previous course?

For other diagnoses:

☐ Yes ☐ No Does the patient have Subacromial impingement?
☐ Yes ☐ No Does the patient have Temporomandibular joint disorder?

For Continuation requests (clinical documentation required):

☐ Yes ☐ No Was the previous course effective for treating the diagnosis or condition?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.