

HYALURONATE CRITERIA FAX REQUEST FORM

Patient Name: _____ Date of Request: _____
 Date of Birth: _____ SW MRN (if available): _____

In order to determine Medicare B coverage for hyaluronate polymers, please complete the following section(s):

Diagnosis ICD-9 code: _____

Select joint being treated:

- Right Knee Bilateral Knee
 Left Knee Other (specify) _____

Select product being requested:

- Hyalgan® (J7321) Supartz® (J7321) Euflexxa® (J7323)
 Orthovisc® (J7324) Synvisc® (J7325) Synvisc 1® (J7325)

If the request is for an initial series of injections, please complete this section:

1. Is the hyaluronate polymer being used for knee pain associated with radiographic evidence of osteophytes in the knee joint, sclerosis in bone adjacent to knee or joint space narrowing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is there morning stiffness of less than 30 minutes in duration OR crepitus on motion of the knee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Can the knee pain be attributed to other forms of joint disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Does the knee pain interfere with functional activities (e.g., ambulation, prolonged standing, ability to sleep)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Is there lack of functional improvement following a trial of at least 3 months of conservative therapy OR is the patient unable to tolerate NSAID therapy due to adverse effects?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If the request is for a repeat series of injections, please provide the following information:

- Has at least 6 months elapsed since the prior series of injections? Yes: (date) _____ No
- Did the patient have a positive response to the prior series of injections demonstrated by significant improvement in pain and functional capacity using a standardized assessment tool **OR** significant reduction in the doses of NSAID medications taken or reduction in the number of intra-articular steroid injections to the knees during the 6-month period following the injection.
 Yes No

Physician Name: _____

Address: _____

Phone: _____ Fax: _____

Physician Signature: _____

Lack of necessary documentation may result in a medical necessity denial.

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