Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Durolane, Euflexxa, Gel-One, Gelsyn 3, GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, sodium hyaluronate 1% injection, Supartz FX, Synojoynt, Synvisc, Synvisc-One, Triluron, Trivisc, Visco-3

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested:
☐ Durolane ☐ Euflexxa ☐ Gel-One ☐ Gelsyn 3
☐ Genvisc 850 ☐ Hyalgan ☐ Hymovis ☐ Monovisc ☐ Orthovisc
☐ sodium hyaluronate 1% injection ☐ Supartz FX ☐ Synojoynt ☐ Synvisc
☐ Synvisc-One ☐ Triluron
☐ Trivisc ☐ Visco-3

Please specify site of injection for this request: ☐ left knee ☐ right knee ☐ both knees
☐ Other:_____

Quantity: Duration of therapy: Jcode: ICD10:

(if Euflexxa, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Orthovisc, sodium hyaluronate 1% injection, Supartz FX, Synojoynt, Triluron, Trivisc or Visco-3) The drug you're requesting is given as a series of weekly injections. Has your patient already started a course of injections with the requested drug? ☐ Yes ☐ No

Please specify drug, sites of injection (one or both knees) and date(s) of injection.

Is this a new start or continuation of therapy?
☐ New Start
☐ Continuation of therapy

(if continuation of therapy) Please indicate the date(s) of the last injection(s) of intra-articular hyaluronic acid products your patient received, including the injection site(s) and product(s) used.

(if continuation of therapy) Has it been 6 months or longer since the last injection or injection series? ☐ Yes ☐ No

(if continuation of therapy) Did your patient have a documented beneficial response since initiating Intraarticular Hyaluronic Acid therapy? ☐ Yes ☐ No

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:

☐ Acute ankle sprain
☐ Osteoarthritis of the knee
☐ Osteoarthritis and Other Pathologic Conditions Involving Joints Other than the Knee
☐ Pathologic Conditions of the Knee Other than Osteoarthritis
☐ Other

Clinical Information

Has your patient's diagnosis been documented by radiologic evidence of osteoarthritis of the knee (for example, joint space narrowing, subchondral sclerosis, osteophytes, subchondral cysts)? ☐ Yes ☐ No

Has your patient tried any of the following:
1. At least six weeks of provider-directed conservative management program consisting of physical therapy or home exercises;
2. At least TWO of the following pharmacologic therapies: oral or topical nonsteroidal anti-inflammatory drug(s) [NSAID(s)], acetaminophen, tramadol, and duloxetine; or
3. At least ONE injection of intra-articular corticosteroids to the affected knee? ☐ Yes ☐ No

How many of the above therapies did the patient have failure to?

☐ Two or more of the above
☐ One of the above
☐ None of the above (patient did not fail any of the alternatives tried)

Please provide names of modalities used, pharmacological therapies tried, or corticosteroids used, including date(s), duration of use, and response to above therapies.

Does the patient have a documented contraindication or intolerance to any of these therapies:
i. Provider-directed conservative management program consisting of physical therapy or home exercises;
ii. Pharmacologic therapies for knee osteoarthritis; or
iii. Intra-articular corticosteroids? ☐ Yes ☐ No

(if yes) How many of the above therapies does the patient have a documented contraindication or intolerance to?

☐ All three of the above
☐ Two of the above
☐ One of the above
☐ None of the above

Please provide specific details on the patient's contraindication or intolerance to the above therapies.

Will the patient be using platelet rich plasma (PRP), stem cell products, amniotic products, corticosteroids with the requested viscosupplement injection? ☐ Yes ☐ No

The covered alternatives* are:
i. Euflexxa; and
ii. Durolane or Gelsyn-3.

For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug. *May need prior auth.

For Euflexxa, per the information provided above, which of the following is true for your patient?
☐ The patient tried this alternative, but it didn't work
☐ The patient tried this alternative, but they did not tolerate it
☐ The patient cannot try the alternative because of a contraindication to this drug
☐ Other

For Durolane or Gelsyn-3, per the information provided above, which of the following is true for your patient?
☐ The patient tried one of these alternatives, but it didn't work
☐ The patient tried one of these alternatives, but they did not tolerate it
☐ The patient cannot try the alternative because of a contraindication to this drug
☐ Other

Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (samples, out of pocket, etc).

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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