GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822

Tel. • 855•552•6028 PA Relay 711
GeisingerHealthPlan.com

Geisinger

INTRA-ARTICULAR HYALURONATES PRIOR AUTHORIZATION FORM *(form effective 1/1/20)*

Prior authorization guidelines for **Intra-Articular Hyaluronates** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan'swebsite at https://healthplan.geisinger.org/pharmacy/pharm acy.aspx?strip=true&style=OneGeisinger

☐ New request ☐ Renewal request	Total # of pages: ______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested:	Dosage form (syringe, vial, etc):

Joint(s) to be injected: ☐ right knee ☐ left knee ☐ other** (specify):______________________

*(**For consideration of treatment for other joints/indication, submit clinical documentation of diagnosis, medical literature supporting the use of the requested agent for the diagnosis, and other therapies that have beentried.)*

Frequency of injection:	Requested duration of therapy:
Diagnosis:	DX code (required):

INITIAL requests

Does the beneficiary have a history of trial and failure, contraindication, or intolerance of any other pharmacologic and non-pharmacologic therapies? *Check all that apply and record specific treatment/therapy. SUBMIT DOCUMENTATION of treatments/therapies tried (or cannot be tried), dates and durations, and outcomes.*

☐ non-drug treatment (list all): ____

____

☐ medications (specify): ☐ acetaminophen ☐ NSAIDs ☐ intra-articular corticosteroid injections ☐ other: ______________

____

Requests for a non-preferred agent: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Intra-articular Hyaluronates? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.*	☐ Yes – *Submit all supporting documentation of trial and failure, contraindications, & intolerances.* ☐ No

RENEWAL requests

Did the requested agent improve the beneficiary's condition and level of functioning following the first treatment?	☐ Yes – *Submit clinical documentation of beneficiary's response to the requested agent.* ☐ No

Record dates all previous Intra-Articular Hyaluronate injections. *SUBMIT CHART DOCUMENTATION of product used and dates of injections.*

☐ right knee	date:__________	date:__________	date:__________	date:__________
☐ left knee	date:__________	date:__________	date:__________	date: __________

Please submit to PromptPA **https://ghp.promptpa.com** OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the indiv idual named abov e. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.