Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Intra-Articular Hyaluronates

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this an initial request or re-authorization request?

☐ Initial request ☐ Re-authorization request

Q2. What is the product being requested?

☐ Preferred Intra-Articular Hyaluronates
☐ Non-Preferred Intra-Articular Hyaluronates
☐ Other

Q3. If other, please specify:

Q4. Is the Intra-Articular Hyaluronate prescribed for the treatment of a diagnosis consistent with the U.S. Food and Drug Administration-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Does the member have a documented history of therapeutic failure of or a contraindication or an intolerance to all of the following?

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☐ Non-pharmacologic treatments
☐ Acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)
☐ Intra-articular glucocorticoid injection
☐ None of the above

Q6. Does the member have a contraindication to the requested agent?

☐ Yes ☐ No

Q7. For a non-preferred Intra-Articular Hyaluronate, does the member have a history of therapeutic failure of or a contraindication or an intolerance of the preferred Intra-Articular Hyaluronates?

☐ Yes ☐ No

Q8. Does the member have documented improvement in pain or joint function following the most recent treatment?

☐ Yes ☐ No

Q9. Did the member receive an Intra-Articular Hyaluronate in the same joint within the past six months?

☐ Yes ☐ No

Q10. Does the member have a contraindication to the requested agent?

☐ Yes ☐ No

Q11. For a non-preferred Intra-Articular Hyaluronate, does the member have a history of therapeutic failure of or a contraindication or an intolerance of the preferred Intra-Articular Hyaluronates?

☐ Yes ☐ No

Q12. Additional Information:

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Member Name:	Prescriber Name:

_____ _____

Prescriber Signature Date

v2026-06