RX.PA.015.MPC HYALURONIC ACID DERIVATIVES

The purpose of this policy is to define the prior authorization process for the hyaluronic acid derivatives.

PREFERRED – PA REQUIRED	NON-PREFERRED – PA REQUIRED	NONFORMULARY SEE CRITERIA BELOW
Single Injection		
Gel-One	Durolane	Synvisc-One
	Monovisc	
Multiple Injections		
Hyalgan	Gelsyn-3	Orthovisc
	Supartz FX	Synvisc
	Trivisc	
	Visco-3	
	Sodium Hyaluronate	
	Genvisc 850	
	Triluron	
	Euflexxa	
	Hymovis	

The hyaluronic acid derivatives are subject to the prior authorization process.

PROCEDURE

A. Initial Authorization Criteria:

Must meet all of the criteria listed below:

- **All products:**
  - Must have a diagnosis of mild-to-moderate osteoarthritis or degenerative joint disease of the knee
  - Must have documentation of a previous trial and failure (at least 3 months), contraindication, or intolerance to simple analgesics (such as acetaminophen-containing products)
  - Must have documentation of a previous trial and failure (at least 3 months), contraindication, or intolerance to at least TWO prescription strength non-steroidal anti-inflammatory drugs (NSAIDs)

- Must have documentation of a trial of steroid injections within the past 2 months and aspiration for effusion without success, or have a documented medical reason to not utilize steroid injections
- Must have documentation of a trial and failure of physician-directed exercise or a physical therapy program

- **For non-preferred products:**
  - Must have documentation of a previous trial and failure, contraindication, or intolerance to 2 preferred products (single or multiple injection)
- **For non-formulary products:**
  - Must have documentation of a previous trial and failure, contraindication, or intolerance to ALL preferred and non-preferred products (single or multiple injection)

Note: Documentation MUST include either paid claims OR specific dates of use for medication trials AND/OR chart documentation from the provider noting a contraindication, intolerance, or failure to all pre-requisite medications

B. Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc) listed in the FDA approved labeling.

C. Hyaluronic acid derivatives will be considered investigational or experimental for any other use and will not be covered.

D. <u>Reauthorization Criteria:</u>

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at 1-year intervals based upon meeting the below criteria:

MPC Renewal:

- Must be at least 6 months since the member completed the prior course of treatment with hyaluronic acid derivatives
- Must have at least ONE of the following objective signs of response to previous therapy for at least 6 months or longer:
  - Decreased joint pain and/or stiffness
  - Improvement in standard indices such as WOMAC osteoarthritis index or Lequesne's functional index
  - Improved knee range of motion
  - Decrease in midpatellar knee circumference in millimeters
  - Synovial effusion absent or volume decreased
  - Decrease in the need for intra-articular agents (anesthetics, corticosteroids), knee aspiration, analgesics, or anti-inflammatory

medications for the management of the treated knee(s) following the previous course of hyaluronic acid derivatives that is consistent with pharmacy claims data

- Must have symptoms of osteoarthritis return
- Must have documentation of a **re-trial** and failure (at least 3 months), contraindication, or intolerance to simple analgesics (such as acetaminophen-containing products)
- Must have documentation of a **re-trial** and failure (at least 3 months), contraindication, or intolerance to at least TWO NSAIDs
- Must have documentation of a **re-trial** of steroid injections within the past 2 months and aspiration for effusion without success, or have a documented medical reason not to utilize steroid injections

Renewal from Previous Insurer:

- Members who have received prior approval (from insurer other than MPC), or have been receiving medication samples, should be considered under criterion A (Initial Authorization Criteria)
- Provider has documented positive clinical response to therapy for the member

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 1 year
Reauthorization	Same as initial

If the established criteria are not met, the request is referred to a Medical Director for review.

HCPCS Codes:

CODE	DESCRIPTION
J7316	Injection, ocriplasmin, 0.125 mg
J7318	Hyaluronan or derivative, Durolane, for intra-articular injection, 1 mg
J7320	Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg
J7321	Hyaluronan or derivative, hyalgan or supartz, for intra-articular injection, per dose
J7322	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose
J7325	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg
J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose

J7328	Hyaluronan or derivative, GELSYN-3, for intra-articular injection, 0.1 mg
J7329	Hyaluronan or derivative, Trivisc, for intra-articular injection, 1 mg
J7332	Hyaluronan or derivative, Triluron, for intra-articular injection, 1 mg
J7333	Hyaluronan or derivative, Visco-3, for intra-articular injection, per dose

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Annual review *Addition of renewal criteria for MPC vs renewal from previous insurer*	*02/2024*
Annual review	*02/2023*
Annual review	*02/2022*
Addition of dosing requirements and off-label restrictions	*12/2021*
P&T Review	*11/2020*