Pharmacy Policy Bulletin

Category:	Medical Injectable Prior Authorization
Number:	J-501
Subject:	Intra-Articular Hyaluronan Injections
Effective Date Begin:	April 1, 2011
Effective Date End:	
Original Date:	November 11, 2010
Review Date(s):	November 11, 2010

Policy Applies to

- Commercial plans

Background

This policy defines the criteria under which coverage for a non-preferred intra-articular hyaluronan product will be considered.

Preferred Product(s)

- Synvisc®, Synvisc-One® (hylan G-F 20)
- Supartz® (sodium hyaluronate)

Applicable Procedure Codes

- J7321: Hyaluronan or derivative, Hyalgan® or Supartz®, for intra-articular injection, per dose
- 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, per dose

Approval Criteria

In order for a request for a non-preferred intra-articular hyaluronan product to be approved:

1. The member must have had an adequate therapeutic trial and experienced a documented drug therapy failure with all applicable preferred intra-articular hyaluronan product **OR**
    a. An "adequate therapeutic trial" consists of using a preferred product at recommended doses for a period of time adequate to assess therapeutic benefit (unless the patient experiences an intolerable adverse effect due to drug therapy within that time period). "Drug therapy failure" consists of not achieving the desired therapeutic goal, development of an intolerable adverse effect due to drug therapy, or development of a hypersensitivity reaction to the drug product. The length of therapy with the preferred product(s) and the reason(s) for drug therapy failure should be documented.
2. The member is being treated with a non-preferred intra-articular hyaluronan product for an indication for which a non-preferred product is FDA-approved and all preferred products are not FDA-approved **OR**
3. The member has a documented allergy to avian products such as feathers, eggs, or poultry and is being treated with a non-preferred intra-articular hyaluronan product that is not derived from an avian source.

Additional Coverage Criteria
Additional criteria may apply to the coverage of both preferred and non-preferred intra-articular hyaluronan products under Highmark medical benefits. Please reference the following Highmark medical policies for potential additional coverage criteria:

- G-25: Intra-Articular Hyaluronan Injections (e.g., Supartz, Hyalgan, Synvisc, Synvisc-One, Euflexxa, and Orthovisc) for Osteoarthritis of the Knee

Intra-articular hyaluronan products are not covered under Highmark prescription drug benefits.