Field Name	Field Description
Prior Authorization Group Desc	**Hyaluronic Acid Derivatives**
Drug(s)	**Preferred:** Euflexxa **Non-Preferred:** Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Supartz FX, TriVisc, Visco-3, Durolane, Hymovis, Monovisc, Orthovisc, Synvisc, Synvisc-One, Triluron, or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), or the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See other criteria
Age Restrictions	According to package insert
Prescriber Restrictions	Prescriber is a rheumatologist, orthopedist, sports medicine specialist, or physiatrist
Coverage Duration	If all of the criteria are met, the request will be approved for one complete course of treatment (based on the FDA labeled dose of the drug requested).
Other Criteria	**Initial Authorization:** • A diagnosis of Osteoarthritis (OA)/Degenerative joint disease (DJD) of the knee. • Documentation (in claim history or provider statement) that the member has had trials of at least 2 oral alternatives (e.g. acetaminophen-containing products, oral NSAIDs, other oral analgesics, etc.) AND a topical NSAID without improvement in pain/function or has a medical reason (intolerance, hypersensitivity, contraindication, etc.) for not being able to utilize these therapies • Documentation has been provided that the member has tried and failed two intraarticular steroid injections, per affected knee, or the member has a medical reason for not being able to utilize steroid injections. • If the request is for any other product other than Euflexxa, the member has a documented medical reason (intolerance, hypersensitivity, contraindication, etc) for not using Euflexxa **Reauthorization:** • Documentation was submitted that the patient had a response to the treated knee(s) that lasted at least 6 months (e.g. decreased

Revision/Review Date: 2/2025	joint pain or stiffness, improved range of motion, etc.). • Documentation was submitted that the patient has a return of symptoms of osteoarthritis that has not responded to acetaminophen-containing products, oral or topical NSAIDs, or other oral analgesics or has a medical reason (intolerance, hypersensitivity, contraindication, etc.) for not being able to utilize these therapies. • If the request is for any other product other than Euflexxa, the member has a documented medical reason (intolerance, hypersensitivity, contraindication, etc) for not using Euflexxa. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**