Pennsylvania
Department of Human Services

Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

INTRA-ARTICULAR HYALURONATES PRIOR AUTHORIZATION FORM *(form effective 7/6/2026)*

Prior authorization guidelines for **Intra-Articular Hyaluronates** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.

☐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:		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 been tried.)*

Frequency of injection:	Requested duration of therapy:
Diagnosis:	Dx code (required):
***Requests for a non-preferred agent*:** Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to 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

INITIAL requests

Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to 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 therapies (list all): _____

☐drug therapies (specify):

- ☐acetaminophen
- ☐intra-articular corticosteroid injections
- ☐NSAIDs
- ☐other: _____

Pennsylvania
Department of Human Services

Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

RENEWAL requests	
Did the requested agent improve the beneficiary's condition and level of functioning?	☐ 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 FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

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 individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.