# EXCEPTIONS CRITERIA

## HYALURONATES

## PREFERRED PRODUCTS (Osteoarthritis-Multi): ORTHOVISC AND SYNVISC
## PREFERRED PRODUCTS (Osteoarthritis-Single): DUROLANE AND SYNVISC-ONE

### POLICY

This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

### I. PLAN DESIGN SUMMARY

This program applies to the hyaluronate products specified in this policy. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to members who are new to treatment with a targeted product for the first time.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

**Table 1. Hyaluronate products (Osteoarthritis-Multi)**

| | Product(s) |
|---|---|
| **Preferred*** | • **Orthovisc** (high molecular weight hyaluronan)<br>• **Synvisc** (hylan G-F 20) |
| **Targeted** | • **Euflexxa** (1% sodium hyaluronate)<br>• **Gelsyn-3** (sodium hyaluronate)<br>• **GenVisc 850** (sodium hyaluronate)<br>• **Hyalgan** (sodium hyaluronate)<br>• **Hymovis** (high molecular weight viscoelastic hyaluronan)<br>• **Supartz FX** (sodium hyaluronate)<br>• **Triluron** (sodium hyaluronate)<br>• **Trivisc** (sodium hyaluronate)<br>• **Visco-3** (sodium hyaluronate) |

*Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

**Table 2. Hyaluronate products (Osteoarthritis-Single)**

| | Product(s) |
|---|---|
| **Preferred*** | • **Durolane** (hyaluronic acid) |

| | |
|---|---|
| | • **Synvisc-One** (hylan G-F 20) |
| **Targeted** | • **Gel-One** (cross-linked hyaluronate)<br>• **Monovisc** (high molecular weight hyaluronan) |

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## II. EXCEPTION CRITERIA

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

### A. Osteoarthritis-Multi

Coverage for a targeted product is provided when either of the following criteria is met:

1. Member has received treatment with the requested targeted product in the past 365 days.
2. Member has a documented intolerable adverse event to both of the preferred products, Orthovisc and Synvisc.

### B. Osteoarthritis-Single

Coverage for a targeted product is provided when either of the following criteria is met:

1. Member has received treatment with the requested targeted product in the past 365 days.
2. Member has a documented intolerable adverse event to both of the preferred products, Durolane and Synvisc-One.

## REFERENCES


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