



Enrollee Last Name:

Grid for Enrollee Last Name (12 boxes)

Enrollee First Name:

Grid for Enrollee First Name (12 boxes)

**Clinical Criteria – Product Information**

**Product Administration:**

Provide the date of product administration (MM/DD/YYYY):

MM / DD / YYYY grid

Provide the expiration date of the product if the invoice date is greater than 6 months from the date of product administration (MM/DD/YYYY):

MM / DD / YYYY grid

**Product Name and Healthcare Common Procedure Coding System (HCPCS) Code:**

EUFLEXXA® – J7323

Gel-One® – J7326

HYALGAN® – J7321

SUPARTZ® – J7321

VISCO-3™ – J7321

Other: \_\_\_\_\_

Strength: \_\_\_\_\_ Directions: \_\_\_\_\_

Quantity: \_\_\_\_\_

New Treatment:  Yes  No

If No, date therapy initiated: \_\_\_\_\_

**Clinical Criteria – Diagnosis**

Arthropathy – disorder of shoulder

Subacromial impingement, syndrome of the shoulder

**Attestation**

*I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.*

Prescriber Signature (Required)

Date (MM/DD/YYYY)