

# Pharmacy PRIOR AUTHORIZATION FORM

Last Reviewed: January 2012

Last Updated: January 2012

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

 This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

**Eylea**<sup>®</sup> (aflibercept), **Lucentis**<sup>®</sup> (ranibizumab),  
**Macugen**<sup>®</sup> (pegaptanib)

 **URGENT** (life threatening)

 **Non-Urgent** (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

### Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

### Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

 \_\_\_\_\_  
 Provider Signature

 \_\_\_\_\_  
 Date

### PRODUCT INFORMATION

 Eylea<sup>®</sup>      **Dose:** 2mg (0.05ml)  every 28 days for 3 months then every 8 weeks

 Lucentis<sup>®</sup>      **Dose:** 0.5mg (0.05ml)  every 28 days  as needed

 Macugen<sup>®</sup>      **Dose:** 0.3mg every 6 weeks

**Start Date:** \_\_\_\_\_

 NOTE: Lucentis<sup>®</sup>, Macugen<sup>®</sup> and Eylea<sup>®</sup> are a non-preferred specialty benefit.

### BILLING INFORMATION

#### Place of administration:

- 
- Provider's Office
- 
- 
- Outpatient facility

Name of facility: \_\_\_\_\_

#### Billing Options:

- 
- Physician buy and bill
- 
- 
- Preferred Specialty Vendor
- 
- 
- Other: \_\_\_\_\_

## PRECERTIFICATION REQUIREMENTS

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### **PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS**

Authorization for Eylea<sup>®</sup> (aflibercept), Lucentis<sup>®</sup> (ranibizumab) and Macugen<sup>®</sup> (pegaptinib) require the following information to certify:

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#### **Patient must have met the following requirements:**

1. Diagnosis of exudative senile macular degeneration (wet age-related macular degeneration (AMD)) with a documented therapeutic trial with Avastin.  
Note: Patients currently receiving Lucentis<sup>®</sup> or Macugen<sup>®</sup> within the immediate 3 months prior to certification request who have demonstrated an adequate response to therapy will not be required to have a documented therapeutic trial and clinical failure with Avastin<sup>®</sup> (bevacizumab).
  2. Lucentis will be authorized for the following diagnoses without step therapy: proliferative diabetic retinopathy, retinal neovascularization NOS, central retinal vein occlusion, venous tributary (branch) occlusion, or retinal edema.
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### **PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION**

Authorization for Eylea<sup>®</sup> (aflibercept), Lucentis<sup>®</sup> (ranibizumab) and Macugen<sup>®</sup> (pegaptinib) require the following information to certify:

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#### **A. What is the patient's diagnosis?**

- 362.52 Exudative senile macular degeneration (continue to item B)

*The following diagnoses are covered for Lucentis<sup>®</sup> only, without step therapy:*

- 362.02 Proliferative diabetic retinopathy  
 362.16 Retinal neovascularization NOS  
 362.35 Central retinal vein occlusion  
 362.36 Venous tributary (branch) occlusion  
 362.83 Retinal edema  
 Other: \_\_\_\_\_ ICD code: \_\_\_\_\_

*Rationale for use:* \_\_\_\_\_

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

#### **B. Has the patient had a documented therapeutic trial with Avastin (bevacizumab)?**

- Yes

Start Date: \_\_\_\_\_

Number of doses administered: \_\_\_\_\_

Results: \_\_\_\_\_

- No

#### **C. Has patient received more than one month of Lucentis<sup>®</sup> or Macugen<sup>®</sup> in the previous 3 months with adequate response to treatment?**

- Yes

- No

\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*

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**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**