PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Iluvien® (fluocinolone acetonide 0.19 intravitreal implant)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Prov. Phone: _____ Prov. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Physician Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Iluvien 0.19 mg intravitreal implant

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

BSA (if applicable):_____

Weight (if applicable):_____

Place of administration:

☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI:_____ Fax:_____

☐ Home infusion

Facility: _____ NPI:_____ Fax:_____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

All fields must be complete and legible for review. Your office will receive a response via fax.

New 07/2018
Last reviewed 07/2018

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be treating diabetic macular edema
2. Must have been previously treated with a course of corticosteroids without a clinically significant rise in intraocular pressure
3. Patient does not have the following:
    - Active ocular or periocular infection
    - Glaucoma

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Diabetic macular edema
☐ Other – rationale for use: _____

B. Does the patient have an active infection of the eye (ocular or periocular)?

☐ Yes. **Rationale for use**: _____
☐ No

C. Does the patient have glaucoma?

☐ Yes. **Rationale for use**: _____
☐ No

D. Has the patient been previously treated with a course of corticosteroids without a clinically significant rise in intraocular pressure?

☐ Yes
☐ No. **Rationale for use**: _____

Additional information

NOTE: If criteria are met, Iluvien will be limited to 1 implant per eye every 36 months.

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