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.

Luxturna™ (voretigene neparvovec-rzyl)

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 Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Luxturna intraocular suspension

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

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): _____

Drug cost information

The wholesale acquisition cost for a treatment course of Luxturna™ is $850,000.

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

New 03/2018
Last reviewed 03/2019

Precertification Requirements

Before this drug is covered, documentation must be submitted to support that the patient meets all of the following requirements:

1. Age 12 months or greater
2. Diagnosis of biallelic RPE65 mutation-associated retinal dystrophy (confirmed by genetic testing)
3. Sufficient viable retinal cells (area within posterior pole of > 100 µm thickness – confirmed by optical coherence tomography)
4. Provider must be ophthalmologist or retinal surgeon
5. Member has not previously received Luxturna™ or another RPE65 gene therapy

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?

☐ *Biallelic RPE65 mutation-associated retinal dystrophy* (documentation of genetic test must be submitted to Priority Health)

☐ Other – the patient's condition is: _____

Rationale for use: _____

B. Does the member have sufficient viable retinal cells (area within posterior pole of > 100 µm thickness) as confirmed by optical coherence tomography (OCT)?

☐ Yes

☐ No; rationale for use: _____

_____

_____

C. Is the request provider an ophthalmologist or retinal surgeon?

☐ Yes

☐ No; Rationale for use: _____

_____

D. Has the member previously received Luxturna™ or other RPE65 gene therapy?

☐ No

☐ Yes; Rationale for use: _____

_____

Additional information

Note: Prior to approving coverage of Luxturna™, a member's plan documents must include coverage for gene therapies with the applicable rider.

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New 03/2018
Last reviewed 03/2019