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.

Macugen® (pegaptanib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Macugen 0.3 mg

Dose:_____ **Dose Frequency**:_____
Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Date of next dose: _____

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): _____

Precertification Requirements

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

1. Diagnosis of Neovascular (wet) age-related macular degeneration (AMD):
   a. Must first try Avastin (bevacizumab) for at least 3 consecutive months with failure to effectively improve baseline visual acuity and/or reduce fluid
   b. Avastin is not required if patient has serous pigment epithelial detachment (PED), hemorrhagic PED, subretinal hemorrhage, or posterior uveal bleeding syndrome
2. Patients currently receiving treatment with Macugen and who have demonstrated an adequate response and who started within the immediate three months are not required to try Avastin

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2017
Last reviewed 01/2019

For continuation, patient must have met the following requirements after 12 months of treatment:

1. Disease response as indicated by stabilization of visual acuity or improvement in BCVA score when compared to baseline.

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.

New Request - Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Neovascular (wet) age-related macular degeneration (AMD)

B. Did the patient have a trial with Avastin (bevacizumab)?

☐ Yes Start date: _____ Number of doses administered: _____

Outcome: _____

☐ No

☐ Patient started Macugen within the previous 3 months with an adequate response to treatment

☐ Other rationale: _____

Continuation - Priority Health Precertification Documentation

A. Provide documentation for continuation:

☐ Patient's visual acuity has stabilized

☐ Patient's BCVA score compared to baseline improved

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Last reviewed 01/2019