PSW
a population health company

PRIOR AUTHORIZATION

EYLEA(AFILIBERCEPT) - BEOVU(BROLUCIZUMAB-DBLL) - LUCENTIS(RANIBIZUMAB)

FAX COMPLETED FORM TO 360.786.8751

MEMBER INFORMATION

MEMBER ID | MEMBER NAME | DOB | PHONE

OTHER INSURANCE (employee, workers comp, VA)

ORDERING / REFERRING PROVIDER

PRIMARY CARE PHYSICIAN	REFERRING/ORDERING PROVIDER NPI
PHONE FAX	PHONE FAX
OFFICE CONTACT	PHONE

REQUESTING PROVIDER / FACILITY

☐ OFFICE
☐ OP HOSPITAL

REQUESTED PROVIDER / FACILITY | SPECIALTY | PLACE OF SERVICE

NPI | PHONE | FAX

IF PROVIDER OR FACILITY IS NON-CONTRACTED, IDICATE REASON BELOW AND SUBMIT DOCUMENTATION WITH REQUEST

☐ NOT AVAILABLE IN PSW NETWORK ☐ OTHER_____

REQUEST TYPE & DATES

☐ **ROUTINE** → Must only include new and continuing treatment for the year.
☐ **RETRO** → Must only include number of retro doses being requested, ANY beyond that require a separate request.
☐ URGENT → **BY CHECKING THIS BOX, I ATTEST THAT WAITING FOR A DECISION UNDER A STANDARD TIMEFRAME COULD ENDANGER THE MEMBER'S LIFE, HEALTH, OR ABILITY TO REGAIN FUNCTIONALITY OR WOULD CAUSE SERIOUS PAIN.**

APPT/PROCEDURE DATE: _____ **AUTH START DATE: _____** ***DURATION OF APPROVAL IS 12 MONTHS**

REQUEST INFORMATION

CPT/HCPCS CODE:_____ **DESCRIPTION**:_____
_____ **DESCRIPTION**:_____
_____ **DESCRIPTION**:_____
ICD10 CODE: _____ **DESCRIPTION**:_____
_____ **DESCRIPTION**:_____
_____ **DESCRIPTION**:_____

REQUEST ORDERS

☐ **LEFT EYE** ☐ **RIGHT EYE** ☐ **BILATERAL EYES**

EYLEA(AFILIBERCEPT) - INITIAL STANDARD ORDER & FREQUENCY:

☐ Wet AMD: 2 mg every 4 weeks (monthly) for the first 3 injections, followed by 2 mg every 8 weeks (Max 8 inj/yr)
☐ DME or DR: 2 mg every 4 weeks (monthly) for the first 5 injections, followed by 2 mg every 8 weeks (Max 8inj/yr)
☐ Macular Edema due to RVO: 2 mg every 4 weeks (12 inj/yr)
*Prescribing outside of the standard is off label and will require additional justification and peer review.

EYLEA(AFILIBERCEPT) - CONTINUATION STANDARD ORDER & FREQUENCY:
☐ Wet AMD: 2 mg every 8 weeks (Max 6 inj/yr)
☐ DME or DR: 2 mg every 8 weeks (Max 6 inj/yr)
☐ Macular Edema due to RVO: 2 mg every 4 weeks (Max12 inj/yr)
*Prescribing outside of the standard is off label and will require additional justification and peer review.

BEOVU(BROLUCIZUMAB-DBLL) - INITIAL STANDARD ORDER & FREQUENCY:
☐ Wet AMD: 6 mg every 4 weeks (monthly) for the first 3 injections, followed by 6 mg every 8-12 weeks (Max 8 inj/yr)
*Prescribing outside of the standard is off label and will require additional justification and peer review.

BEOVU(BROLUCIZUMAB-DBLL) - CONTINUATION STANDARD ORDER & FREQUENCY:
☐ Wet AMD: 6 mg every 8-12 weeks (Max 6 inj/yr)
*Prescribing outside of the standard is off label and will require additional justification and peer review.

LUCENTIS(RANIBIZUMAB) - INITIAL/CONTINUING STANDARD ORDER & FREQUENCY:
☐ Wet AMD/ Macular Edema due to RVO: 0.5 mg every 4 weeks (Max 12 inj/yr)
☐ DME or DR: 0.3 mg every 4 weeks (Max 12 inj/yr)
☐ mCNV: 0.5 mg every 4 weeks, up tp 3 months (Max 3 inj/yr)
*Prescribing outside of the standard is off label and will require additional justification and peer review.

CLINICAL INFORMATION – REQUIRED SUPPORTING CLINICAL DOCUMENTATION MUST ACCOMPANY ALL REQUESTS

1. **Is this request for:** ☐ Initiation ☐ Continuation Date patient started therapy: _____

2. **Initiation AND Continuation of Therapy Request:**
   a. **What is the patient's diagnosis?**
      ☐ Neovascular (wet) age related macular degeneration (AMD)
      ☐ Macular edema due to retinal vein occlusion (RVO)
      ☐ Diabetic Macular edema (DME)
      - Is the patient's visual acuity in the affected eye(s) equal to or worse than 20/50? ☐ Yes ☐ No

      ☐ Diabetic Retinopathy (DR)
      ☐ Myopic choroidal neovascularization (mCNV)
      ☐ Other, Please specify:_____
   b. **Has the patient tried Avastin therapy?** ☐ Yes ☐ No
      - If yes, what was the response?

        _____
   c. **Has the patient failed treatment with other anti-VGEF therapy?** ☐ Yes ☐ No
      - If yes, List what treatment(s) patient failed:

        _____

3. **Continuation of therapy request:**
   a. **How has the patient's condition changed while on therapy?**
      ☐ Improved; Please describe: _____
      ☐ Stable; Please describe: _____
      ☐ Worsened; Please describe: _____
      ☐ Other; Please describe: _____

CLINICAL INFORMATION – REQUIRED SUPPORTING CLINICAL DOCUMENTATION MUST ACCOMPANY ALL REQUESTS

Additional Information: _____

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