HEALTH PLANS
UNIVERSITY OF UTAH

MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM

OPHTHALMIC VEGF INHIBITORS

Avastin®, Eylea®, Lucentis®, Macugen®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Avastin® (bevacizumab)*, ☐ Eylea® (aflibercept)**, ☐ Lucentis® (ranibizumab)***
Non-preferred: ☐ Macugen® (bevacizumab)
*preferred first line, **preferred second line, ***preferred third line

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider an ophthalmologist or in consultation with one?	☐	☐	
3. Does the member have a diagnosis of diabetic macular edema, age-related macular edema, or macular edema following a retinal vein occlusion?	☐	☐	**Please provide documentation**
4. Does the member have a baseline visual acuity score?	☐	☐	**Please provide documentation**
5. For Eylea®, does documentation show a trial and failure of Avastin®?	☐	☐	**Please provide documentation**
6. For Lucentis®, does documentation show a trial and failure of Avastin® and Eylea®?	☐	☐	**Please provide documentation**
7. For Macugen®, does documentation show a trial and failure of Avastin®, Eylea®, and Lucentis®?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Do updated clinical notes show a positive response to therapy and a continued medical necessity?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- M005
Origination Date: 03/30/2016
Reviewed/Revised Date: 05/06/2019
Next Review Date: 05/09/2020
Current Effective Date: 05/09/2019