Updated: 04/2019
PARP Approved: 04/2019

Gateway Health
Prior Authorization Criteria
Lucentis (ranibizumab)

All requests for Lucentis (ranibizumab) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Lucentis (ranibizumab) Prior Authorization Criteria:

For all requests for Lucentis (ranibizumab) all of the following criteria must be met:

- The member is 18 years of age or older
- The treatment is prescribed by, or in consultation with, an ophthalmologist
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- The member does not have an active ocular or periocular infection
- The member has tried and failed or had an intolerance to Avastin

Coverage may be provided with a diagnosis of Neovascular (Wet) Age-Related Macular Degeneration (AMD).

Coverage may be provided with a diagnosis of Macular Edema Following Retinal Vein Occlusion.

Coverage may be provided with a diagnosis of Diabetic Macular Edema and the following criteria is met:

- Must provide documentation of clinically significant macular edema (CSME) defined as any of the following:
    - Retinal thickening within 500 µm of the macular center
    - Hard exudates within 500 µm of the macular center with adjacent retinal thickening
    - One or more disc diameters of retinal thickening, part of which is within one disc diameter of the macular center

Coverage may be provided with a diagnosis of Diabetic Retinopathy.

Coverage may be provided with a diagnosis of Myopic Choroidal Neovascularization.

Initial Duration of Approval: 12 months
Reauthorization criteria

- Diagnosis of Neovascular (Wet) Age-Related Macular Degeneration, Macular Edema Following Retinal Vein Occlusion, Diabetic Macular Edema, Diabetic Retinopathy, or Myopic Choroidal Neovascularization

Reauthorization Duration of Approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

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LUCENTIS (ranibizumab)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty: ☐Opthalmologist ☐Other:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

☐ Neovascular (Wet) Age-Related Macular Degeneration (AMD) ICD-10 Code: _____
☐ Macular Edema following Retinal Vein Occlusion ICD-10 Code: _____
☐ Diabetic Macular Edema ICD-10 Code: _____
☐ Diabetic Retinopathy ICD-10 Code: _____
☐ Myopic Choroidal Neovascularization ICD-10 Code: _____
☐ Other: _____ ICD-10 Code: _____

Does the member have an active ocular or periocular infection? ☐ Yes ☐ No
Has the member tried and failed Avastin? ☐ Yes ☐ No

For the diagnosis of Diabetic Macular Edema:
Must provide documentation of clinically significant macular edema (CSME) defined as any of the following:

- Retinal thickening within 500 µm of the macular center
- Hard exudates within 500 µm of the macular center with adjacent retinal thickening
- One or more disc diameters of retinal thickening, part of which is within one disc diameter of the macular center

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

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LUCENTIS (ranibizumab)
PRIOR AUTHORIZATION FORM (CONTINUED)– PAGE 2 of 2

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PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date