Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

Requirements for Prior Authorization of Macular Degeneration Agents

A. Prescriptions That Require Prior Authorization

All prescriptions for Macular Degeneration Agents must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Macular Degeneration Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication; **AND**

2. Is prescribed the medication by a retinal specialist; **AND**

3. **One** of the following:

   a. Has a history of therapeutic failure of or a contraindication or an intolerance to intravitreal bevacizumab
   b. Cannot use intravitreal bevacizumab because of medical reasons as documented by the prescriber (e.g., beneficiary has neovascular (wet) age-related macular degeneration or geographic atrophy);

   AND

4. Is prescribed a dose and frequency that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

5. For a non-preferred Macular Degeneration Agent, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Macular Degeneration Agents approved or medically accepted for the beneficiary's diagnosis. See the Preferred Drug List (PDL) for the list of preferred Macular Degeneration Agents at: https://papdl.com/preferred-drug-list;

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR MACULAR DEGENERATION AGENTS: The determination of medical necessity of a request for renewal of a prior authorization for a Macular Degeneration Agent that was previously approved will take into account whether the beneficiary:

1. Is prescribed the medication by a retinal specialist; **AND**

2. Has documentation of previous date(s) of administration; **AND**

3. Has documentation of a positive clinical response based on the prescriber's assessment; **AND**

4. Is prescribed a dose and frequency that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

5. For a non-preferred Macular Degeneration Agent, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Macular Degeneration Agents approved or medically accepted for the beneficiary's diagnosis. See the PDL for the list of preferred Macular Degeneration Agents at: https://papdl.com/preferred-drug-list;

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Macular Degeneration Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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MACULAR DEGENERATION AGENTS PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	Total # pages: _____	Prescriber name:		
Name of office contact:		Specialty:		
Contact's phone number:		State license #:		NPI:
LTC facility contact/phone:		Street address:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:		Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Formulation (syringe, vial, etc.):
Directions (dose, eye[s] to be treated, frequency, etc.):		Requested duration:
Diagnosis:		Dx code *(required)*:

INITIAL requests

Has the beneficiary tried and failed or have a contraindication or an intolerance to intravitreal bevacizumab?	☐Yes – *Submit all supporting documentation of bevacizumab regimen and treatment outcome.* ☐No ☐Not clinically appropriate
For a non-preferred medication: Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance of the preferred agents in this class that are approved or medically accepted for the beneficiary's diagnosis? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes – *Submit documentation.* ☐No ☐Not applicable to diagnosis

RENEWAL requests

List previous doses of the requested medication:

Right eye: _____

Left eye: _____

Has the beneficiary experienced a positive clinical response to previously administered doses of the requested medication?	☐Yes ☐No *Submit medical record documentation of beneficiary's response to treatment.*

PLEASE FAX COMPLETED FORM TO HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	**Date**: