Updated: 05/2019
DMMA Approved: 05/2019

Request for Prior Authorization for Visudyne (verteporfrin)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Visudyne (verteporfrin) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Visudyne (verteporfrin) Prior Authorization Criteria:

For all requests for Visudyne (verteporfrin) 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

Coverage may be provided with a diagnosis of Age Related Macular Degeneration and the following criteria is met:

- The member has had a trial and failure of a vascular endothelial growth factor (VEGF) inhibitor (e.g. Avastin), or submitted a clinical reason for not having a trial of a vascular endothelial growth factor (VEGF) inhibitor (e.g. Avastin)

Coverage may be provided with a diagnosis of Subfoveal Choroidal Neovascularization and the following criteria is met:

- Must provide documentation showing neovascularization is due to pathologic myopia, or presumed ocular histoplasmosis

Initial Duration of Approval: 12 months

Reauthorization criteria

- Member continues to meet initial criteria for medical necessity

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.

HIGHMARK. Delaware HEALTH OPTIONS

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VISUDYNE (VERTEPORFRIN) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options 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:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

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: ICD-10 _____

Age Related Macular Degeneration:

Has the member tried and failed a VEGF inhibitor (e.g. Avastin) or is there a clinical reason for not having a trial of a VEGF inhibitor? ☐ Yes ☐ No

Subfoveal Choroidal Neovascularization:

Is the neovascularization due to pathologic myopia or presumed ocular histoplasmosis? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date