

Updated: 05/2019 DMMA Approved: 05/2019

HEALTH OPTIONS DMMA Ap Request for Prior Authorization for Visudyne (verteporfrin) Website Form – <u>www.highmarkhealthoptions.com</u> 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 <u>diagnosis</u> 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 <u>diagnosis</u> 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.



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VISUDYNE (VERTEPORFRIN)
PRIOR AUTHORIZATION FORM

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

HEALTH OPTIONS

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6253 Monday through Eriday 8:30am to 5:00pm

PROVIDER INFORMATION         Requesting Provider:       NP:         Provider Specialty:       Office Contact:         Office Address:       Office Phone:         Office Address:       Office Phone:         Office Address:       Office Fax:         Member Name:       DOB:         Health Options ID:       Member weight:pounds or         REQUESTED DRUG INFORMATION       Medication:         Strength:       Frequency:         Is the member currently receiving requested medication?       Ves         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         Place of Service:       Hospital       Provider's office         Place of Service:       Hospital       Provider's office         Place of Service:       NPI:         Address:       NPI:         Address:       Phone:         MEDICAL HISTORY (Complete for ALL requests)         Diagnosis: ICD-10       Ne         Age Related Macular Degeneration:       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         CURRENT or PR	rno	<b>INE</b> . $(844)$ 323-0233 WORD						
Provider Specialty:       Office Contact:         Office Address:       Office Fone:         Office Address:       Office Fone:         Office Name:       DOB:         Member Name:       DOB:         Health Options ID:       Member weight:         Prequency:       Duration:         Strength:       Frequency:         Is the member currently receiving requested medication?       Yes         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         Date Medication initiated:       Is a pharmacy OR         Is this medication will be billed:       at a pharmacy OR         Immedically (if medically please provide a JCODE:		PROVIDER	INFORMA					
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Prescribing Provider Signature Date	Prescribing Provider Signature		Date					



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