Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. 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, intolerance, or contraindication to intravitreal bevacizumab
   b. Cannot use intravitreal bevacizumab because of clinical reasons as documented by the prescriber (e.g., beneficiary has neovascular (wet) age-related macular degeneration);

4. Is prescribed a dose, and frequency that is consistent with FDA-approved package labeling or nationally recognized compendia or is medically accepted; **AND**

5. For a non-preferred Macular Degeneration Agent, has a history of therapeutic failure, intolerance, or contraindication of 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; **AND**

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**

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

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

4. Is prescribed a dose and frequency that is consistent with FDA-approved package labeling or nationally recognized compendia or is medically accepted

   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.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

Gateway Health
It's Wholecare.

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:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other	

CLINICAL INFORMATION

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

Medication requested: *(all agents require prior authorization)*	☐Eylea ☐Lucentis	☐Macugen ☐Visudyne	☐_______________
Strength:	Formulation: ☐vial ☐syringe	☐_______________	Frequency:
Eye(s) to be treated:	☐right eye ☐left eye ☐both eyes	☐_______________	Requested duration:

INITIAL requests

Does the beneficiary have one of the following diagnoses? *Indicate beneficiary's diagnosis.* ☐diabetic macular edema ☐diabetic retinopathy → ☐with diabetic macular edema ☐without diabetic macular edema ☐macular edema following retinal vein occlusion (RVO) ☐myopic choroidal neovascularization ☐neovascular (wet) age-related macular degeneration (AMD) ☐subfoveal choroidal neovascularization (predominantly classical)	☐Yes – *Submit medical record documentation supporting diagnosis.* ☐No – *Submit documentation of medical literature supporting the use of the requested agent for the beneficiary's diagnosis.*
What is the corresponding diagnosis code for the beneficiary's diagnosis?	Dx code *(required)*: _______________
Has the beneficiary tried and failed or have a contraindication or 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, contraindication, or intolerance of the preferred agents in this class that are approved or medically accepted for the beneficiary's diagnosis?	☐Yes ☐No *Submit documentation.*

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 GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.