Updated: 04/2019
PARP Approved: 06/2019

Prior Authorization Criteria

Eylea (Aflibercept)

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

For all requests for Eylea (Aflibercept) 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 member does not have active intraocular inflammation, ocular or periocular infection.
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to the following:
    - Avastin

Coverage may be provided with a diagnosis of neovascular (wet) age-related macular degeneration.

Coverage may be provided with a diagnosis of macular edema following retinal vein occlusion.

Coverage may be provided with a diagnosis of central-involved diabetic macular edema and the following criteria is met:

- The member has Clinically Significant Macular Edema defined as having **ONE** or more of the following:
    - Thickening of the retina at or within 500 μm of the center of the macula
    - Hard exudates at or within 500 μm of the center of the macula, when associated with adjacent retinal thickening. (This criteria does not apply to residual hard exudates that remain after successful treatment of prior retinal thickening.)
    - Retinal thickening one disc area or larger, where any portion of the thickening is within one disc diameter of the center of the macula
    - Confirmation of the diagnosis by an (OCT) Optical Coherence Tomography

Coverage may be provided with a diagnosis of diabetic retinopathy with central-involved diabetic macular edema.

- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Must provide chart documentation demonstrating clinical benefit and tolerance to Eylea
- **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

Updated: 04/2019
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EYLEA (AFLIBERCEPT)
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:	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)

Is the patient 18 years of age or older? Yes ☐ No ☐
Is the prescriber an ophthalmologist? Yes ☐ No ☐
Does the member have an active ocular or periocular infection? Yes ☐ No ☐
Please mark the box indicating the patient's diagnosis:

☐ Neovascular (wet) age-related macular degeneration

☐ Macular edema following retinal vein occlusion

☐ Central-involved diabetic macular edema

☐ Diabetic retinopathy with central-involved diabetic macular edema

For a diagnosis of Diabetic retinopathy with central-involved diabetic macular edema which of the following was used to confirm diagnosis?

☐ Thickening of the retina at or within 500 μm of the center of the macula
☐ Hard exudates at or within 500 μm of the center of the macula, when associated with adjacent retinal thickening.
☐ Retinal thickening one disc area or larger, where any portion of the thickening is within one disc diameter of the center of the macula
☐ Confirmation of the diagnosis by an (OCT) Optical Coherence Tomography

☐ Other: _____

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EYLEA (AFLIBERCEPT)
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

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date