Updated: 06/2019
DMMA Approved: 06/2019

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

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

Eylea (aflibercept) Prior Authorization Criteria:

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 Avastin (bevacizumab)

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 diabetic retinopathy

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

Initial Duration of Approval: 12 months
Reauthorization criteria

- 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.

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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 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, 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:

☐ Neovascular (wet) age-related macular degeneration
☐ Macular edema following retinal vein occusion
☐ Diabetic retinopathy
☐ Central-involved diabetic macular edema. Indicate which of the following applies:
- ☐ Diagnosis confirmed by Optical Coherence Tomography (OCT)
- ☐ 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

☐ Other: _____ ICD-10: _____

Does the member have an active ocular or periocular infection? ☐ Yes ☐ No

Has the member tried Avastin? ☐ Yes, see below for details ☐ No, please explain below

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Has the member experienced clinical benefit from treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date