Updated: 06/2022
DMMA Approved: 06/2022

Request for Prior Authorization for Macular Degeneration Agents
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Macular Degeneration Agents require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Macular Degeneration Agents Prior Authorization Criteria:

Drugs addressed in this policy: Beovu (Brolucizumab), Eylea (Aflibercept), Lucentis (Ranibizumab), Susvimo (ranibizumab), Vabysmo (faricimab-svoa), Visudyne (Verteporfin) and Macugen (Pegaptanib).

For all requests for Macular Degeneration Agents, the following criteria must be met in addition to the diagnosis specific criteria:

- The member is 18 years of age or older
- The requested medication is being prescribed for a diagnosis that is indicated in the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- The treatment is prescribed by, or in consultation with, an ophthalmologist or retinal specialist
- The member does not have active ocular or periocular infection.
    - If requesting Vabysmo, Beovu, Susvimo or Eylea, member must also not have active intraocular inflammation
- 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) or a bevacizumab biosimilar agent (may require prior authorization).

Initial Duration of Approval: 12 months

Reauthorization criteria

- Chart documentation demonstrating clinical benefit and tolerance to therapy

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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MACULAR DEGENERATION AGENTS 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) 325-6251 Monday through Friday 8:00am to 7:00pm

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:	
Directions:	Quantity:	Refills:
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 occlusion
☐ 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
Does the member have active intraocular inflammation? ☐ 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