HIGHMARK HEALTH OPTIONS

Updated: 08/2025
DMMA Approved: 08/2025

Request for Prior Authorization for Vascular Endothelial Growth Factor Inhibitors (VEGF) and Visudyne (verteporfin)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Vascular Endothelial Growth Factor Inhibitors (VEGF) and Visudyne (verteporfin) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below. ***This policy does not apply to oncology related requests.***

Vascular Endothelial Growth Factor Inhibitors (VEGF) and Visudyne (verteporfin) Prior Authorization Criteria:

For all requests for Vascular Endothelial Growth Factor Inhibitors (VEGF) and Visudyne (verteporfin), the following criteria must be met in addition to the diagnosis specific criteria:

- 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
- **Initial Duration of Approval:** 12 months

Reauthorization criteria

- Chart documentation demonstrating clinical benefit and tolerance to therapy

Reauthorization Duration of Approval: 12 months

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VASCULAR ENDOTHELIAL GROWTH GACTOR INHIBITORS (VEGF) AND VISUDYNE (VERTEPROFEN) 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 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

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:	ICD Code:
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 or an Avastin biosimilar? ☐ 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 an improvement with treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date