Updated: 04/2019
DMMA Approved: 04/2019

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

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

Lucentis (ranibizumab) Prior Authorization Criteria:

For all requests for Lucentis (ranibizumab) 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 requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- The member does not have an active ocular or periocular infection
- The member has tried and failed or had an intolerance to Avastin

Coverage may be provided with a diagnosis of Neovascular (Wet) Age-Related Macular Degeneration (AMD).

Coverage may be provided with a diagnosis of Macular Edema Following Retinal Vein Occlusion.

Coverage may be provided with a diagnosis of Diabetic Macular Edema and the following criteria is met:

- Must provide documentation of clinically significant macular edema (CSME) defined as any of the following:
    - Retinal thickening within 500 µm of the macular center
    - Hard exudates within 500 µm of the macular center with adjacent retinal thickening
    - One or more disc diameters of retinal thickening, part of which is within one disc diameter of the macular center

Coverage may be provided with a diagnosis of Diabetic Retinopathy.

Coverage may be provided with a diagnosis of Myopic Choroidal Neovascularization.

Initial Duration of Approval: 12 months
Reauthorization criteria:
- Member continues to meet initial criteria for medical necessity

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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LUCENTIS (ranibizumab)
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 (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)

Diagnosis:

☐ Neovascular (Wet) Age-Related Macular Degeneration (AMD) ICD-10 Code: _____
☐ Macular Edema following Retinal Vein Occlusion ICD-10 Code: _____
☐ Diabetic Macular Edema ICD-10 Code: _____
☐ Diabetic Retinopathy ICD-10 Code: _____
☐ Myopic Choroidal Neovascularization ICD-10 Code: _____
☐ Other: _____ ICD-10 Code: _____

Does the member have an active ocular or periocular infection? ☐ Yes ☐ No
Has the member tried and failed Avastin? ☐ Yes ☐ No

For the diagnosis of Diabetic Macular Edema:
Must provide documentation of clinically significant macular edema (CSME) defined as any of the following:

- Retinal thickening within 500 µm of the macular center
- Hard exudates within 500 µm of the macular center with adjacent retinal thickening
- One or more disc diameters of retinal thickening, part of which is within one disc diameter of the macular center

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LUCENTIS (ranibizumab)
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

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MEMBER INFORMATION

Member Name:	DOB:
Health Options 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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date