OPTIMA HEALTH FAMILY CARE (MEDICAID)

MEDICAL/PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-723-2094**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

Macular Degeneration Drugs (Medical)

❑ **URGENT REVIEW. In checking this box, prescriber attests to the fact that by applying the standard review timeframe may seriously jeopardize the member's life, health, or ability to regain maximum function.**

❑ **STANDARD REVIEW**. In checking this box, the timeframe does **NOT** jeopardize the life or health of the member or the member's ability to regain maximum function and would **NOT** subject the member to severe pain.

Drug Requested: Check box below that applies.		
PREFERRED ❑ **Avastin®** (bevacizumab) **(J9035)**		
Non-Preferred		
❑ **Macugen®** (pegaptanib sodium injection) **(J2503)**	❑ **Lucentis®** (ranibizumab) **(J2778)**	❑ **Eylea®** (afliberept) injection **(J0178)**

DRUG INFORMATION: Complete **all** information below or authorization will be delayed.

Drug Form/Strength: ____

Dosing Schedule: ______________________ **Diagnosis:** ______________________

Diagnosis: ______________________________ **ICD Code:** ______________

CLINICAL CRITERIA/DIAGNOSIS. Check below **ALL** that apply. **ALL** criteria/diagnoses **must** be met for approval. To support each line checked, **ALL** documentation, including lab results, diagnostics, and/or chart notes, **must** be provided or request will be denied. **(If Avastin is checked, identify individual's condition below.)**

- ❑ Member was diagnosed with **ONE** of the following:
  - ❑ Neovascular (wet) age-related macular degeneration **(AMD)**
  - ❑ Diabetic macular edema **(DME)**
  - ❑ Macular edema following retinal vein occlusion **(MEfRVO)**
  - ❑ Neovascular glaucoma

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- ❑ Other rare cause of choroidal neovascularization for **one or more** of the following conditions:
  - ❑ Angioid streaks
  - ❑ Choroiditis **(including, but not limited to histoplasmosis induced choroiditis)**
  - ❑ Degenerative idiopathic myopia
  - ❑ Retinal dystrophies
  - ❑ Trauma
  - ❑ Pseudoxanthoma elasticum
  - ❑ Retinopathy of prematurity
  - ❑ Other: ____

❑ **Macugen®**. Check below **ALL** that apply for approval. To support each line checked, **ALL** documentation, including lab results, diagnostics, and/or chart notes, **must** be provided or request will be denied.

- ❑ Has member tried and failed Avastin® for **30 days** and documented in chart notes the reason for failing the **Preferred** drug? ❑ Yes ❑ No

AND

- ❑ Member was diagnosed for Neovascular (wet) age-related macular degeneration **(AMD)**? ❑ Yes ❑ No

❑ **Lucentis®**. Check below **ALL** that apply. Criteria **must** be met for approval. To support each line checked, **ALL** documentation, including lab results, diagnostics, and/or chart notes, **must** be provided or request will be denied.

- ❑ Has member tried and failed Avastin® for 30 days and documented in chart notes the reason for failing the **Preferred** drug? ❑ Yes ❑ No

AND

- ❑ Has member been diagnosed with **ONE** of the following labeled indications? ❑ Yes ❑ No
  - ❑ Diabetic macular edema **(DME)**
  - ❑ Diabetic retinopathy **(DR)**
  - ❑ Neovascular (wet) age-related macular degeneration **(AMD)**
  - ❑ Macular edema following retinal vein occlusion **(MEfRVO)**
  - ❑ Myopic choroidal neovascularization **(mCNV)**

❑ **Eylea®.** Check below **ALL** that apply. Criteria **must** be met for approval. To support each line checked, **ALL** documentation, including lab results, diagnostics, and/or chart notes, **must** be provided or request will be denied.

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(Signature page MUST be included with request)

- ❑ Has member tried and failed Avastin® for 30 days and documented in chart notes the reason for failing the Preferred drug? ❑ Yes ❑ No

AND

- ❑ Has member been diagnosed with **ONE** of the following labeled indications? ❑ Yes ❑ No
  - ❑ Neovascular (wet) age-related macular degeneration **(AMD)**
  - ❑ Diabetic macular edema **(DME)**
  - ❑ Diabetic retinopathy **(DR)** with and/or without DME
  - ❑ Macular edema following retinal vein occlusion **(MEfRVO)**

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** ____

  NPI or DEA # of administering location: ____

OR

- ❑ **Specialty Pharmacy - PropriumRx**

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: ____

Member Optima #: ____ Date of Birth: ____________________

Prescriber Name: ____

Prescriber Signature: ____ Date: ______________________

Office Contact Name: ____

Phone Number: _____________________________________ Fax Number: _________________________

DEA OR NPI #: ____

**Approved by Pharmacy and Therapeutics Committee:*
REVISED/UPDATED: 6/6/2019; **(Reformatted) 7/16/2019**