OPTIMA HEALTH PLAN

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.**

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

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®** (aflibercept) 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:

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- ❑ Neovascular (wet) age-related macular degeneration **(AMD)**
- ❑ Diabetic macular edema **(DME)**
- ❑ Macular edema following retinal vein occlusion **(MEfRVO)**
- ❑ Neovascular glaucoma
- ❑ 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 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)**

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❑ **Eylea®.** Check below **ALL** 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

❑ 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.*

Member 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) 7/7/2019**;