aetna®

Lucentis® (ranibizumab) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Ophthalmologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Lucentis (ranibizumab): Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests: (clinical documentation required for all requests)

What is the patient's BCVA (best corrected visual acuity) prior to initiating treatment: ____/____ (e.g., 20/320)

☐ Yes ☐ No Is this request for intravitreal injection of the eye?
→ Please indicate which eye: ☐ OD (right eye) ☐ OS (left eye) ☐ OU (both eyes)

☐ Yes ☐ No Will Lucentis (ranibizumab) be given in conjunction with another vascular endothelial growth factor inhibitor?
→ ☐ Yes ☐ No Will the medication be given in the same eye as Lucentis (ranibizumab)?

☐ Yes ☐ No Does the patient have any of the following contraindications to Lucentis (ranibizumab)? (check all that apply)
→ ☐ Endophthalmitis ☐ Ocular infection ☐ Periocular infection ☐ Hypersensitivity

Please identify which documented diagnosis the patient is being treated for:

- ☐ Diabetic retinopathy
- ☐ Diabetic macular edema
- ☐ Macular edema following retinal vein occlusion (RVO)
- ☐ Myopic Choroidal Neovascularization (mCNV)
- ☐ Neovascular (wet) (age related macular degeneration) AMD
- ☐ Neovascular glaucoma
- ☐ Polypoidal choroidal vasculopathy
- ☐ Pseudoxanthoma elasticum
  → ☐ Yes ☐ No Is this a request for re-treatment?

Continued on next page

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Rare causes of choroidal neovascularization
→ Please identify the cause of choroidal neovascularization:
☐ Angioid streaks ☐ Choroiditis (including choroiditis secondary to ocular histoplasmosis) ☐ Idiopathic degenerative myopia
☐ Retinal dystrophies ☐ Rubeosis iridis ☐ Trauma ☐ Other: Please identify: _____
☐ Yes ☐ No Is this a request for re-treatment?
→ What is the length of treatment being requested? ☐ 3 months or less ☐ Greater than 3 months

☐ Retinopathy of prematurity
→ Please indicate the stage of disease: ☐ Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ Stage 4 ☐ Stage 5

For Continuation Requests:

Please indicate length of time on Lucentis (ranibizumab): _____
Please indicate the patient's current BCVA: _____/_____ (e.g., 20/320)
Please choose the patient response: ☐ BCVA has improved ☐ BCVA has remained the same
☐ Small vision loss (defined as maximum of 3 lines or 15 letters lost on visual acuity exam)
☐ None of the above

☐ Yes ☐ No Has the patient had improvement in field vision?
☐ Yes ☐ No Has the patient experienced a hypersensitivity reaction to Lucentis (ranibizumab)?
→ Please indicate which of the following hypersensitivity reactions the patient experienced:
☐ anaphylactoid reactions ☐ pruritus ☐ rash ☐ severe anaphylactic reactions ☐ severe intraocular inflammation
☐ urticaria ☐ Other: Please explain: _____

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Lucentis (ranibizumab)? (Sampling of Lucentis (ranibizumab) does not guarantee coverage under the provisions of the pharmacy benefit)

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.