aetna®

Luxturna® (voretigene neparvovec-rzyl) 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 #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
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: _____
Phone: _____ Fax: _____
Address: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Luxturna (voretigene neparvovec-rzyl): 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: (Supporting documentation must be provided for review, including the copy of the genetic test)

Please indicate which eye the treatment is being requested for? ☐ Right eye ☐ Left eye ☐ Both eyes

☐ Yes ☐ No Has the patient had Luxturna (voretigene neparvovec-rzyl) in the past?
→ Please select the eye which was treated in the past: ☐ Right eye ☐ Left eye ☐ Both eyes

☐ Yes ☐ No Does the patient have a documented diagnosis of retinal dystrophy?
→ ☐ Yes ☐ No Is there a confirmation of bi-allelic pathogenic and/or likely pathogenic RPE65 mutation?
→ Please indicate which of the following genetic test was performed to confirm bi-allelic pathogenic and/or likely pathogenic RPE65 mutation:
☐ Single gene test ☐ Multi gene panel test ☐ None of the above
Please provide the date of the test: ____/____/____
☐ Yes ☐ No Are the RPE65 gene mutations classifications based on the ACMG standards and guidelines for the interpretation of sequence variants (2015)?

☐ Yes ☐ No Does the patient have viable retinal cells as confirmed by a retinal specialist?
→ Which of the following test(s) was performed to confirm that the patient has viable retinal cells? (select all that apply)
☐ Optical coherence tomography (OCT) ☐ Ophthalmoscopy ☐ None of the above
Please indicate the result of the test:
☐ An area of retina within the posterior pole of greater than 100 µm thickness shown on OCT
☐ Greater than or equal to 3 disc areas of retina without atrophy or pigmentary degeneration within the posterior pole
☐ Remaining visual field within 30 degrees of fixation as measured by a III4e isopter or equivalent
☐ None of the above

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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.

For both eyes request only: Please provide the date administration of Luxturna (voretigene neparvovec-rzyl) to each eye will occur:

Right eye: ____/____/____ Left eye: ____/____/____

Please provide the name of a designated ocular gene therapy treatment center Luxturna (voretigene neparvovec-rzyl) will be administered at:

Name: _____

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.