Macugen® (pegaptanib sodium) Injectable Medication Precertification Request

(All fields must be completed and return both pages 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: ____________________
Address: ____________________
Phone: __________ Fax: __________
TIN: __________ PIN: __________

E. PRODUCT INFORMATION

Macugen: Dose: ____________________ **Directions for Use:** ____________________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

Primary ICD Code: ____________________ ☐ **Other ICD Code**: ____________________

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For *All* Requests: (Supporting documentation ***must*** be provided for review)

☐ Yes ☐ No Is this request for intravitreal injection of the eye? **If yes**, please indicate: ☐ OD (right eye) ☐ OS (left eye) ☐ OU (both eyes)

☐ Yes ☐ No Will Macugen be given in conjunction with another vascular endothelial growth factor inhibitor?

→ ☐ Yes ☐ No Will the medication be given in the same eye as Macugen?

Does the patient have any of the following contraindications to Macugen? (check all that apply)

☐ Active intraocular inflammation ☐ Ocular infection ☐ Periocular infection ☐ Hypersensitivity

Please identify which diagnosis the patient is being treated for:

☐ Neovascular (wet) age related macular degeneration (AMD)

☐ Macular edema

→ Please identify the cause of the macular edema the patient will be treated for:

☐ Age-related macular degeneration ☐ Blockage in small veins of retina due to radiation, macular telangiectasis ☐ Eye surgery

☐ Diabetic macular edema ☐ Genetic disorder ☐ Inflammatory disease of the retina ☐ Medication side effects

☐ Macular edema following retinal vein occlusion ☐ Uveitis ☐ Other: Please explain: ____________________

☐ Other diagnosis: Please explain: ____________________

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

For *Continuation* Requests:

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

Please indicate the patient's current BCVA: _____/_____ (e.g., 20/320)

Please choose the best 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)

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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.

☐ Yes ☐ No Has the patient had improvement in field vision?

☐ Yes ☐ No Has the patient experienced a hypersensitivity reaction to Macugen?

→ 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: ______________________

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.