aetna®

MEDICARE FORM

Lucentis® (ranibizumab), Byooviz™ (ranibizumab-nuna), Cimerli™ (ranibizumab-eqrn) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
FAX: 1-844-268-7263
PHONE: 1-866-503-0857

For other lines of business:
Please use other form.

Note: Lucentis, Byooviz, and Cimerli are non-preferred. The preferred product is bevacizumab (Avastin). Avastin (C9257) and Avastin biosimilars do not require precertification for ophthalmic use.

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:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	E-mail:	
Current Weight: ____ lbs or ____ kgs Height: ____ inches or ____ cms		Allergies:		

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

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

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 Email:		Office Contact Name:		Phone:	

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: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Lucentis (ranibizumab)** ☐ **Byooviz (ranibizumab-nuna)** ☐ **Cimerli (ranibizumab-eqrn)**
Dose: _____ **Frequency:** _____ **HCPCS code:** _____

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)

Note: Lucentis, Byooviz, and Cimerli are non-preferred. The preferred product is bevacizumab (Avastin). Avastin (C9257) and Avastin biosimilars do not require precertification for ophthalmic use.

☐ Yes ☐ No Has the patient had prior therapy with Lucentis (ranibizumab), Byooviz (ranibizumab-nuna), or Cimerli (ranibizumab-eqrn) within the last 365 days?

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to bevacizumab (Avastin)?

Please explain if there are any other medical reason(s) that the patient cannot use bevacizumab (Avastin)

_____

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

Continued on next page

aetna®

MEDICARE FORM

Lucentis® (ranibizumab), Byooviz™ (ranibizumab-nuna), Cimerli™ (ranibizumab-eqrn) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
FAX: 1-844-268-7263
PHONE: 1-866-503-0857

For other lines of business:
Please use other form.

Note: Lucentis, Byooviz, and Cimerli are non-preferred. The preferred product is bevacizumab (Avastin). Avastin (C9257) and Avastin biosimilars do not require precertification for ophthalmic use.

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.

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

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

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.