



# MEDICARE FORM

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

Page 1 of 2

(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 and Byooviz are non-preferred. The preferred product is bevacizumab (Avastin). Avastin (C9257), Aylmsys, Mvasi, and Zirabev 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 #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____			
Insured: _____		Insured: _____			
C. PRESCRIBER INFORMATION					
First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	
D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION					
<b>Place of Administration:</b>			<b>Dispensing Provider/Pharmacy:</b>		
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office			<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy		
<input type="checkbox"/> Outpatient Infusion Center Phone: _____			<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order		
Center Name: _____			<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Home Infusion Center Phone: _____			Name: _____		
Agency Name: _____			Address: _____		
<input type="checkbox"/> Administration code(s) (CPT): _____			City: _____ State: _____ ZIP: _____		
Address: _____			Phone: _____ Fax: _____		
City: _____ State: _____ ZIP: _____			TIN: _____ PIN: _____		
Phone: _____ Fax: _____			NPI: _____		
TIN: _____ PIN: _____					
NPI: _____					
E. PRODUCT INFORMATION					
Request is for: <input type="checkbox"/> Lucentis (ranibizumab) <input type="checkbox"/> Byooviz (ranibizumab-nuna)					
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.					
<b>For All Requests: (clinical documentation required for all requests)</b>					
<b>Note: Lucentis and Byooviz are non-preferred. The preferred product is bevacizumab (Avastin). Avastin (C9257), Aylmsys, Mvasi, and Zirabev do not require precertification for ophthalmic use.</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had prior therapy with Lucentis (ranibizumab) or Byooviz (ranibizumab-nuna) within the last 365 days?					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a trial, 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)					
<input type="checkbox"/> Yes <input type="checkbox"/> No Is this request for intravitreal injection of the eye?					
→ Please indicate which eye: <input type="checkbox"/> OD (right eye) <input type="checkbox"/> OS (left eye) <input type="checkbox"/> OU (both eyes)					
<input type="checkbox"/> Yes <input type="checkbox"/> No Will Lucentis (ranibizumab) be given in conjunction with another vascular endothelial growth factor inhibitor?					
→ <input type="checkbox"/> Yes <input type="checkbox"/> No Will the medication be given in the same eye as Lucentis (ranibizumab)?					
<input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have any of the following contraindications to Lucentis (ranibizumab)? (check all that apply)					
→ <input type="checkbox"/> Endophthalmitis <input type="checkbox"/> Ocular infection <input type="checkbox"/> Periocular infection <input type="checkbox"/> Hypersensitivity					

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**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): \_\_\_\_\_

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)?

**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.