



MEDICARE FORM

SUSVIMO™ (ranibizumab) Injectable Medication Precertification Request

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(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: Susvimo is non-preferred.

The preferred product is bevacizumab (Avastin).

Avastin (C9257), Almysys, 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:		Allergies:			
Current Weight: ____ lbs or ____ kgs		Height: ____ inches or ____ cms			

B. INSURANCE INFORMATION

Member ID #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #:	If yes, provide ID#: _____ Carrier Name: _____	
Insured:	Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:

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:	
Provider E-mail:			Office Contact Name:		Phone:
Specialty (Check one): <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: (Patient selected choice)	
<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"/> Other: _____	
Center Name: _____		Name: _____	
<input type="checkbox"/> Home Infusion Center Phone: _____		Address: _____	
Agency Name: _____		Phone: _____ FAX: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ PIN: _____	
Address: _____		NPI: _____	
NPI: _____			

E. PRODUCT INFORMATION

Request is for: SUSVIMO (ranibizumab)

Dose: _____ Frequency: _____ HCPCS code: _____

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

Primary ICD Code: _____ Other ICD Code: _____

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

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

Note: Susvimo is non-preferred. The preferred product is bevacizumab (Avastin). Avastin (C9257), Almysys, Mvasi, and Zirabev do not require precertification for ophthalmic use.

- Yes No Has the patient had prior therapy with Susvimo (ranibizumab) within the last 365 days?
- Yes 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)

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

- Yes No Has the patient previously responded to at least two intravitreal injections of a Vascular Endothelial Growth Factor (VEGF) inhibitor (e.g., Avastin, Eylea) within the past 6 months?
- Yes No Will the requested medication be used in conjunction with Susvimo ocular implant?
- Yes No Has the patient had an ineffective response, contraindication or intolerance to Avastin?

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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.

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

Yes No Has the patient demonstrated a positive clinical response to therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss)?

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.