



MEDICARE FORM

VABYSMO™ (faricimab-svoa) 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: Vabysmo is non-preferred.

The preferred product is bevacizumab (Avastin).

Avastin (C9257), Alymsys, 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

Form section A: Patient Information. Fields include First Name, Last Name, DOB, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, E-mail, Current Weight, Height, and Allergies.

B. INSURANCE INFORMATION

Form section B: Insurance Information. Fields include Member ID #, Group #, Insured, Medicare status, Medicaid status, and other coverage details.

C. PRESCRIBER INFORMATION

Form section C: Prescriber Information. Fields include First Name, Last Name, Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Office Contact Name, and Specialty.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Administration Information. Divided into Place of Administration and Dispensing Provider/Pharmacy details.

E. PRODUCT INFORMATION

Form section E: Product Information. Fields include Request is for (VABYSMO), Dose, Frequency, and HCPCS code.

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

Form section F: Diagnosis Information. Fields include Primary ICD Code and Other ICD Code.

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

Form section G: Clinical Information. Includes initiation request notes, patient history questions, and diagnosis selection (Diabetic macular edema, Neovascular AMD).

Continued on next page



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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.