



**Luxturna® (voretigene neparvovec-rzyl)
Injectable Medication
Precertification Request**

Page 1 of 2

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-7021
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:	Email:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms	

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: _____
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 Email:		Office Contact Name:		Phone:	

Specialty (Check one): Ophthalmologist Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Phone: _____ Fax: _____ Address: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for Luxturna (voretigene neparvovec-rzyl): Dose: _____ **Frequency:** _____

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: (Supporting documentation must be provided submitted)

Yes No Has the patient been diagnosed with bi-allelic RPE65 mutation-associated retinal dystrophy?

Yes No Is there a confirmation of bi-allelic pathogenic and/or likely pathogenic RPE65 mutation?

Action Required: Attach genetic test results (single gene test or multi gene panel test) confirming a genetic diagnosis of pathogenic/likely pathogenic biallelic RPE65 gene mutations.

→ Please indicate which of the following genetic test was performed to confirm bi-allelic pathogenic and/or likely pathogenic RPE65 mutation:
 Single gene test Multi gene panel test None of the above
 Please provide the date of the test: ____ / ____ / ____

Yes No Are the RPE65 gene mutations classifications based on the current American College of Medical Genetics and Genomics (ACMG) standards and guidelines for the interpretation of sequence variants?

Yes No Has pathogenicity of the RPE65 mutations been affirmed with then last 12 months?

Yes No Does the patient have viable retinal cells as confirmed by a retinal specialist?

→ Which of the following test(s) was performed to confirm that the patient has viable retinal cells? (select all that apply):
 Optical coherence tomography
 Ophthalmoscopy
 Optical coherence tomography (OCT) and Ophthalmoscopy
 None of the above

Please indicate the result of the test:
 An area of retina within the posterior pole of greater than 100 µm thickness shown on optical coherence tomography (OCT)
 Greater than or equal to 3 disc areas of retina without atrophy or pigmentary degeneration within the posterior pole
 Remaining visual field within 30 degrees of fixation as measured by a III4e isopter or equivalent
 None of the above

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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 indicate which eye the treatment is being requested for? Right eye Left eye Both eyes

Yes No Has the patient had Luxturna (voretigene neparvovec-rzyl) in the past?
 → Please select the eye which was treated in the past: Right eye Left eye Both eyes

For both eyes request only: Please provide the date administration of Luxturna (voretigene neparvovec-rzyl) to each eye will occur:
 Right eye: ____ / ____ / ____ Left eye: ____ / ____ / ____

Please provide the name of a designated ocular gene therapy treatment center Luxturna (voretigene neparvovec-rzyl) will be administered at:
 Name: _____

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.