



MEDICARE FORM

Lucentis® (ranibizumab) 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 is non-preferred.

The preferred product is bevacizumab (Avastin). Avastin (C9257), 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:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	
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: _____

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

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: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____	Dispensing Provider/Pharmacy: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____
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E. PRODUCT INFORMATION

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

Yes No Has the patient had prior therapy with Lucentis (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)

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



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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.