



**Lucentis[®] (ranibizumab),
Byooviz[™] (ranibizumab) Injectable
Medication Precertification Request**

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(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

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:		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

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:		<i>(Check one):</i> <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 <i>(Check one):</i> <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Other: _____							

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: <i>(Patient selected choice)</i>	
<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: _____			

E. PRODUCT INFORMATION

Request is for: Lucentis (ranibizumab) Byooviz (ranibizumab)

Dose: _____ Directions for Use: _____

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

Primary ICD Code: _____ Other ICD Code: _____

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

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

Please select the diagnosis:

Diabetic macular edema

Diabetic retinopathy

Macular edema following retinal vein occlusion (RVO)

Myopic choroidal neovascularization

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

Yes No Has the patient had an ineffective response, contraindication or intolerance to Avastin?

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.