

EYLEA & LUCENTIS

Prior Authorization Form

- Standard Request (72 hours)
 Expedited Request (24 hours)

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	<input type="checkbox"/> Generic <input type="checkbox"/> Brand Necessary
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>		
<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

<input type="checkbox"/> Billed by PHARMACY dispensed to the member or provider for administration.	<input type="checkbox"/> Billed under MEDICAL benefit by provider. J CODE: _____ ICD-10 Code: _____	Place of Administration: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient Home
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Clinical Information

Diagnosis Code: _____	Date Diagnosed: _____
<input type="checkbox"/> Diabetic retinopathy associated with diabetic macular edema <input type="checkbox"/> Neovascular (wet) age-related macular degeneration	<input type="checkbox"/> Macular edema following retinal vein occlusion <input type="checkbox"/> Diabetic Macular Edema
Is the provider a retinal specialist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member have active intraocular inflammation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member have an active ocular or periocular infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide any additional information which should be considered in the space below:
