Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Luxturna (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Luxturna (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Luxturna (voretigene neparvovec-rzyl)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Does the patient have vision loss due to biallelic RPE65 mutation-associated retinal dystrophy? Y N

   [If no, no further questions.]

2. Were the biellelic mutations in the PRE65 gene confirmed through genetic testing? Y N

   [If no, no further questions.]

3. Is the patient 12 months through 64 years of age? Y N

   [If no, no further questions.]

4. Does the patient have viable retinal cells as determined by a healthcare professional? If yes, indicate the (planned) date of service: _____. Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**