

Encelto™ (revakinagene taroretcel-lwey) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information Physician billing (HCPCS code: _____) Pharmacy billing (NDC: _____)
Start Date: _____**Billing Provider Information**Provider NPI: _____ Provider Name: _____
Provider Phone: _____ Provider Fax: _____**Prescriber Information**Prescriber NPI: _____ Prescriber Name: _____
Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____**Criteria****For Authorization:** (a limit of 1 implant per eye per lifetime will apply)1. Clinical documentation (i.e., recent office notes) must be submitted with the request documenting the member's treatment plan. Is this information attached? Yes No

2. Please indicate the diagnosis and information

 Idiopathic Macular Telangiectasia (MacTel)a. Is diagnosis idiopathic MacTel type 2? Yes No

b. Does the member have evidence of the following features typical of MacTel Type 2:

i. Fluorescein leakage? Yes No ii. Hyperpigmentation that is outside of a 500-micron radius from the center of the fovea?
Yes No iii. Retinal opacification? Yes No iv. Crystalline deposits? Yes No v. Right-angle vessels? Yes No vi. Inner/outer lamellar cavities? Yes No c. Is Encelto™ prescribed by and will it be administered by a qualified ophthalmologist under aseptic conditions? Yes No d. Does member have a photoreceptor inner segment/outer segment (IS/OS PR) break (loss) in ellipsoid zone (EZ) between 0.16 and 2.00mm² measured by spectral domain-optical coherence tomography (SD-OCT)? Yes No e. Does member have a best corrected visual acuity (BCVA) of 20/80 or better? Yes No f. Does member have neovascular MacTel type 2? Yes No g. Does member have ocular or periocular infections? Yes No h. Does member have known hypersensitivity to Endothelial Serum Free Media (Endo-SFM)?
Yes No **(Page 1 of 2)**

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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2. Please indicate the diagnosis and information: (continued)

- i. Is the member taking an antithrombotic medication (i.e., oral anticoagulants, aspirin, and nonsteroidal anti-inflammatory drugs)? Yes No
 - i. If yes, has member been counseled to temporarily discontinue therapy with their antithrombotic medication prior to Encelto™ implantation due to the risk of vitreous hemorrhage? Yes No
- j. Will the member be monitored for vision loss, infectious endophthalmitis, retinal tear and/or detachment, vitreous hemorrhage, implant extrusion, cataract formation, suture related complications, and delayed dark adaptation after Encelto™ implantation and treated, if appropriate? Yes No
- k. Will both eyes be treated? Yes No
- l. Please provide the date(s) of the scheduled procedure(s), if applicable:
 - i. Right eye: _____
 - ii. Left eye: _____

Other: _____

Additional Information: _____

(Page 2 of 2)

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.

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