aetna™

MEDICARE FORM

Lucentis® (ranibizumab) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

For Virginia HMO SNP:
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

For other lines of business:
Please use other form.

Note: Lucentis is non-preferred. The preferred product is Avastin or bevacizumab biosimilar. Avastin and bevacizumab biosimilar do not require precertification.

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 #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ 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:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

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 Avastin or bevacizumab biosimilar.

☐ 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 Avastin (bevacizumab) or bevacizumab biosimilar?

Please explain if there are any other medical reason(s) that the patient cannot use Avastin (bevacizumab) or bevacizumab biosimilar.

_____

_____

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

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?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ 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.