



MEDICARE FORM

VABYSMO™ (faricimab-svoa) Injectable Medication Precertification Request

Page 1 of 2

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

For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934 (TTY: 711)

For other lines of business:
Please use other form.

Note: Vabysmo is non-preferred. The preferred products are bevacizumab (Avastin) first followed by Byooviz. Avastin (C9257) and bevacizumab biosimilars do not require precertification for ophthalmic use.

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

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ NPI: _____	Dispensing Provider/Pharmacy: (Patient selected choice) <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ FAX: _____ TIN: _____ PIN: _____ NPI: _____
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E. PRODUCT INFORMATION

Request is for: VABYSMO (faricimab-svoa)
Dose: _____ Frequency: _____ HCPCS code: _____

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 Initiation Requests (clinical documentation required for all requests):
Note: Vabysmo is non-preferred. The preferred products are bevacizumab (Avastin) first followed by Byooviz. Avastin (C9257) and bevacizumab biosimilars do not require precertification for ophthalmic use.

Yes No Has the patient had prior therapy with Vabysmo (faricimab-svoa) within the last 365 days?
 Yes No Has the patient had a trial and failure, intolerance, or contraindication to bevacizumab (Avastin)?
 Yes No Has the patient had a trial and failure, intolerance, or contraindication to Byooviz (ranibizumab-nuna)?

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

Please explain if there are any other medical reason(s) that the patient cannot use Byooviz (ranibizumab-nuna).

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Please select the diagnosis:

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

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.