aetna®

MEDICARE FORM

Beovu® (brolucizumab-dbll) Injectable Medication Precertification Request

(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: Beovu 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 #: _____
Group #: _____
Insured: _____

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

Medicare: ☐ Yes ☐ No If yes, provide ID #:

Medicaid: ☐ Yes ☐ No If yes, provide ID #:

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:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Ophthalmologist** ☐ **Other**: _____

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: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*

☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____

Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for Beovu (brolucizumab-dbll) Dose: _____ **Directions for Use:** _____

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 All Requests: (clinical documentation required for all requests)

Note: Beovu 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 Beovu (brolucizumab-dbll) 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

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

For Initiation Requests (clinical documentation required for all requests):

Please select the diagnosis:

☐ Neovascular (wet) age related macular degeneration

☐ Other: _____

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.