# MEDICARE FORM

# Lucentis® (ranibizumab), Byooviz™ (ranibizumab-nuna), Cimerli™ (ranibizumab-eqrn) Injectable Medication Precertification Request



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

**For Illinois MMP:**
**FAX:** 1-855-320-8445
**PHONE:** 1-866-600-2139 (TTY: 711)

**For other lines of business:**
Please use other form.

**Note: Lucentis and Cimerli are 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

**Aetna 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 Email: | | 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: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

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

## E. PRODUCT INFORMATION

**Request is for:** ☐ **Lucentis (ranibizumab)** ☐ **Byooviz (ranibizumab-nuna)** ☐ **Cimerli (ranibizumab-eqrn)**
**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 Lucentis or Cimerli Requests: (clinical documentation required for all requests)**

**Note: Lucentis and Cimerli are 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 Lucentis (ranibizumab) or Cimerli (ranibizumab-eqrn) 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).

_____

***Continued on next page***

aetna®

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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 Byooviz Requests: (clinical documentation required for all requests)**

**Note: Bevacizumab (Avastin) is preferred first prior to Byooviz. Avastin (C9257) and bevacizumab biosimilars do not require precertification for ophthalmic use.**

☐ Yes ☐ No Has the patient had prior therapy with Byooviz (ranibizumab-nuna) within the last 365 days?

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to bevacizumab (Avastin)?

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

_____

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?
☐ 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), Byooviz (ranibizumab-nuna), or Cimerli (ranibizumab-eqrn): _____

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), Byooviz (ranibizumab-nuna), or Cimerli (ranibizumab-eqrn)?
→ 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), Byooviz (ranibizumab-nuna), or Cimerli (ranibizumab-eqrn)?

**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.