Eylea

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)* ❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)* ❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

What is the ICD-10 code? _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

 JHHC Eylea SGM 2024-A - 10/2023.

Criteria Questions:

1. Please indicate which of the following drugs this request is for?

❒ Eylea, *Continue to 2*

❒ Eylea HD, *Continue to 3*

2. What is the diagnosis?

❒ Diabetic macular edema, *Continue to 4*

❒ Diabetic retinopathy, *Continue to 4*

❒ Neovascular (wet) age-related macular degeneration, *Continue to 4*

❒ Macular edema following retinal vein occlusion, *Continue to 4*

❒ Retinopathy of prematurity, *Continue to 4*

❒ Other, please specify. _____, *Continue to 4*

3. What is the diagnosis?

❒ Diabetic macular edema, *Continue to 4*

❒ Diabetic retinopathy, *Continue to 4*

❒ Neovascular (wet) age-related macular degeneration (AMD), *Continue to 4*

❒ Other, please specify. _____, *Continue to 4*

4. Is this a request for continuation of therapy?

❒ Yes, *Continue to 5*

❒ No, *No Further Questions*

5. 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)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756