Visudyne

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 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:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

<u>Rendering</u> 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.

<u>Required Demographic Information:</u>

Patient Weight: __________________________*kg*

Patient Height: __________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

<u>Drug Information:</u>
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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Visudyne SGM 3011-A – 08/2023.

Criteria Questions:

1. What is the diagnosis?

❒ Predominantly classic subfoveal choroidal neovascularization (*If checked, go to 2*)

❒ Choroidal hemangioma (*If checked, go to 3*)

❒ Other, please specify. __________________________ (*If checked, no further questions*)

2. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 6*

❒ No, *Continue to 4*

3. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 6*

❒ No, *No Further Questions*

4. Does the patient have predominantly classic subfoveal choroidal neovascularization (CNV) due to one of the following?

❒ Yes, age-related macular degeneration (*If checked, go to 5*)

❒ Yes, pathologic myopia (*If checked, go to 5*)

❒ Yes, presumed ocular histoplasmosis (If checked, go to 5)

❒ Yes, chronic central serous chorioretinopathy (also includes retinal pigment epithelial leakage without evident CNV) (*If checked, go to 5*)

❒ No (*If checked, go to 5*)

5. Is the treatment spot size less than or equal to 6.4 mm in diameter?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

6. Has the patient demonstrated a positive clinical response to the requested drug therapy?

❒ 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)**

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