HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
OPHTHALMIC INJECTIONS

Avastin®,Beovu®, Byooviz™, Cimerli™, Eylea®, Lucentis®, Macugen®, Susvimo™, Syforve™, Vabysmo™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Avastin® (bevacizumab) prior authorization not required, ☐ Byooviz™ (ranibizumab-nuna), ☐ Cimerli™ (ranibizumab-eqrn), ☐ Eylea® (aflibercept)
Non-preferred: ☐ Beovu® (brolucizumab-dbll), ☐ Lucentis® (ranibizumab), ☐ Macugen® (pegaptanib), ☐ Susvimo™ (ranibizumab implant), ☐ Syforve™ (pegcetacoplan), ☐ Vabysmo™ (faricimab-svoa)
*preferred first line, **preferred second line, ***preferred third line

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider an ophthalmologist or in consultation with one?	☐	☐	
3. Does the member have a diagnosis of diabetic macular edema (DME), diabetic retinopathy (DR) in patients with DME, age-related macular edema (AMD), myopic choroidal neovascularization (mCNV), or macular edema following a retinal vein occlusion (RVO)?	☐	☐	**Please provide documentation**
4. Does the member have a baseline visual acuity score?	☐	☐	**Please provide documentation**
5. For Beovu®, does documentation show a trial and failure of Avastin® and Eylea®?	☐	☐	**Please provide documentation**
6. For Byooviz™, does documentation show a diagnosis of AMD, RVO or mCNV and a trial and failure of Avastin® and Eylea®?	☐	☐	**Please provide documentation**
7. For Cimerli™, does documentation show a diagnosis of DME or DR and trial and failure of Avastin® and Eylea®?	☐	☐	**Please provide documentation**
8. For Eylea®, does documentation show a trial and failure of Avastin®?	☐	☐	**Please provide documentation**

9. For Lucentis®, does documentation show a trial and failure of Avastin®, Byooviz™ or Cimerli™, and Eylea®?	☐	☐	**Please provide documentation**
10. For Macugen®, does documentation show a trial and failure of Avastin®, Byooviz™ or Cimerli™, and Eylea®?	☐	☐	**Please provide documentation**
11. For Susvimo™, does documentation show a trial and failure of Avastin®, Byooviz™ or Cimerli™, and Eylea®?	☐	☐	**Please provide documentation**
12. For Syforve™, does the member have a best corrected visual acuity score and a diagnosis of geographic atrophy of the macula secondary to age-related macular degeneration?	☐	☐	**Please provide documentation**
13. For Vabysmo™, does documentation show a trial and failure of Avastin®, Byooviz™ or Cimerli™, and Eylea®?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Do updated clinical notes show a positive response to therapy and a continued medical necessity?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy PHARM-HCU-M005
Origination Date: 01/01/2022
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