



# MEDICARE FORM

## Eylea® (aflibercept) Injectable Medication Precertification Request

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(All fields must be completed and legible for Precertification Review.)

For Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

For other lines of business:

Please use other form.

**Note: Eylea is non-preferred.**

**The preferred product is Avastin or bevacizumab biosimilar. Avastin and bevacizumab biosimilar do not require precertification.**

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:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	
Current Weight: ___ lbs or ___ kgs		Height: ___ inches or ___ cms	

### B. INSURANCE INFORMATION

Member ID #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured: _____

### C. PRESCRIBER INFORMATION

First Name:	Last Name:	(Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.		
Address:	City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:
Office Contact Name:				UPIN:
				Phone:

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	<b>Dispensing Provider/Pharmacy:</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Phone: _____ Fax: _____ Address: _____ TIN: _____ PIN: _____
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### E. PRODUCT INFORMATION

Request is for Aflibercept (Eylea): 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: \_\_\_\_\_ HCPCS Code: \_\_\_\_\_

### G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

**For All Requests:** (Supporting documentation *must* be provided for review)

**Note: Eylea is non-preferred. The preferred product is Avastin or bevacizumab biosimilar. Avastin and bevacizumab biosimilar do not require precertification.**

Yes  No Has the patient had prior therapy with Eylea (aflibercept) within the last 365 days?

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

Yes  No Is the patient's visual acuity 20/50 or worse?

Please explain if there are any medical reason(s) that the patient cannot use Avastin (bevacizumab) or bevacizumab biosimilar: \_\_\_\_\_

Please indicate the patient's BCVA prior to initiating treatment: \_\_\_/\_\_\_ (e.g., 20/320)

Yes  No Is this request for intravitreal injection of the eye? **If yes**, please indicate:  OD (right eye)  OS (left eye)  OU (both eyes)

Yes  No Will aflibercept (Eylea) be given in conjunction with another vascular endothelial growth factor inhibitor?

Yes  No Will the medication be given in the same eye as aflibercept (Eylea)?

Yes  No Does the patient have any of the following contraindications to aflibercept (Eylea)? (check all that apply)

Ocular infection  Periocular infection  Hypersensitivity  Endophthalmitis

Please identify which documented diagnosis the patient is being treated for:

Diabetic Macular edema (including diabetic retinopathy in persons with macular edema)

Macular edema following retinal vein occlusion (RVO) (including central retinal vein occlusion (CRVO) and branch retinal vein occlusion (BRVO))

Myopic choroidal neovascularization (mCNV)  Neovascular (wet) (age related macular degeneration) AMD

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION (continued)** – Required clinical information must be completed in its entirety for all precertification requests.

**For Continuation Requests:**

Please indicate length of time on aflibercept (Eylea): \_\_\_\_\_

Please indicate the patient's current BCVA: \_\_\_\_/\_\_\_\_ (e.g., 20/320)

Please choose the best 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 aflibercept (Eylea)?

→ 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 aflibercept (Eylea)?

**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.