AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Intravitreal Complement Inhibitors (Medical)

Drug Requested: (Select drug below)

❑ **Izervay™** (avacincaptad pegol) **(J2782)**	❑ **Syfovre™** (pegcetacoplan) **(J2781)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Quantity Limit:

- Izervay – Maximum 1 vial per eye per 28 days; 1 vial = 20 billable units
- Syfovre – Maximum 1 vial per eye per 25 days; 1 vial = 15 billable units

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Recommended Dosage:

- Izervay – 2 mg (0.1 mL of 20 mg/mL solution) administered by intravitreal injection to each affected eye once monthly (approximately every 28 ± 7 days)
- Syfovre – 15 mg (0.1 mL of 150 mg/mL solution) administered by intravitreal injection to each affected eye once every 25 to 60 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- ❑ Provider is an Optometry Specialist or an Ophthalmologist
- ❑ Member has a diagnosis of geographic atrophy (GA) confirmed by **ALL** the following:
  - ❑ Defined by a phenotype of central geographic atrophy having 1 or more zones of well demarcated retinal pigmented epithelium (RPE) and/or choriocapillaris atrophy
  - ❑ Disease is secondary to age-related macular degeneration (AMD)
  - ❑ Conditions other than AMD have been ruled out (e.g., Stargardt disease, cone rod dystrophy, toxic maculopathies such as plaquenil maculopathy in either eye)
- ❑ Provider has submitted member's baseline for at least **ONE** of the following:
  - ❑ Best Corrected visual acuity (BCVA) score: _____
  - ❑ Fundus autofluorescence (FAF) imaging: _____
  - ❑ Optical coherence tomography (OCT): _____
- ❑ Requested medication will **NOT** be used in combination with other intravitreal complement inhibitor therapies
- ❑ Member does **NOT** have category 6, or higher, visual impairment or blindness (i.e., no light perception-total blindness)
- ❑ Provider is requesting **ONE** of the following dosing frequencies:
  - ❑ Monthly
  - ❑ Every other month

Reauthorization: 12 months. All criteria that apply must be checked for approval. To support each line checked all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Member has had disease stabilization or slowing rate of disease progression while on therapy compared to previous baseline as measured by at least **ONE** the following:
  - ❑ Member's best corrected visual acuity (BCVA) has improved or stabilized from baseline
  - ❑ Member's fundus autofluorescence (FAF) imaging has improved or stabilized from baseline
  - ❑ Member's optical coherence tomography (OCT) has improved or stabilized from baseline

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- ❑ Provider attests continued administration is necessary for the maintenance treatment of the condition and both member and provider have discussed potential decrease in frequency of administration if receiving monthly
- ❑ Member has experienced an absence of unacceptable toxicity from the drug including but not limited to endophthalmitis, retinal detachment, neovascular (wet) AMD or choroidal neovascularization, intraocular inflammation (e.g., vitritis, vitreal cells, iridocyclitis, uveitis, anterior chamber cells, iritis, and anterior chamber flare), increased intraocular pressure, that cannot be adequately treated

Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.