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.

Macular Degeneration Drugs (Medical)

Drug Requested: Check box below that applies.

PREFERRED		
❑ **Avastin®** (bevacizumab) **(J9035)**		
❑ **bevacizumab 1.25 mg/0.05 mL (3 mg/0.12 mL) intravitreal injection (J9035)**		
NON-PREFERRRED		
❑ **Beovu®** (brolucizumab) **(J0179)**	❑ **Byooviz™** (ranibizumab-nuna) **(Q5124)**	❑ **Cimerli™** (ranibizumab-eqrn) **(Q5128)**
❑ **Eylea®** (aflibercept) **(J0178)**	❑ **Eylea® HD** (aflibercept) **(J0177)**	❑ **Lucentis®** (ranibizumab) **(J2778)**
❑ **Pavblu™** (aflibercept-ayyh) **(Q5147)**	❑ **Susvimo®** (ranibizumab) **(J2779)**	❑ **Vabysmo®**(faricimab-svoa) **(J2777)**

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 #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

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

❑ 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.

❑ Left Eye ❑ Right Eye ❑ Both Eyes

Preparations & Billable Units:

Medication	Billable Units
Beovu® (brolucizumab) **6 mg/0.05 mL solution**	1 syringe = 6 billable units
Byooviz™ (ranibizumab-nuna) **0.5 mg/0.05 mL solution**	1 vial = 5 billable units
Cimerli® (ranibizumab-eqrn) **0.3 mg/0.05 mL solution**	1 vial = 3 billable units
Cimerli® (ranibizumab-eqrn) **0.5 mg/0.05 mL solution**	1 vial = 5 billable units
Eylea® (aflibercept) **2 mg/0.05 mL solution**	1 vial/syringe = 2 billable units
Eylea® HD (afliberept) **8 mg/0.07 mL solution**	1 vial = 8 billable units
Lucentis® (ranibizumab) **0.3 mg/0.05 mL solution**	1 syringe = 3 billable units
Lucentis® (ranibizumab) **0.5 mg/0.05 mL solution**	1 syringe = 5 billable units
Pavblu™ (aflibercept-ayyh) **2 mg/0.05 mL solution**	1 vial/syringe = 2 billable units
Susvimo® (ranibizumab) **10 mg/0.1 mL implant**	1 vial/kit = 100 billable units
Vabysmo®(faricimab-svoa) **6 mg/0.05 mL solution**	1 vial = 60 billable units

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.

❑ **Avastin®/bevacizumab 1.25 mg/0.05 mL (3 mg/0.12 mL) intravitreal injection.** 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.

- ❑ Provider has submitted member's baseline best corrected visual acuity (BCVA) score: _____
- ❑ Member has been diagnosed with **ONE** of the following labeled indications:
  - ❑ Diabetic macular edema **(DME)**
  - ❑ Diabetic retinopathy **(DR)**
  - ❑ Neovascular (wet) age-related macular degeneration **(AMD)**
  - ❑ Macular edema following retinal vein occlusion **(MEfRVO)**
  - ❑ Myopic choroidal neovascularization **(mCNV)**
  - ❑ Neovascular glaucoma

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- ❑ Other rare causes of choroidal neovascularization for **ONE or more** of the following conditions:
  - ❑ Angioid streaks
  - ❑ Choroiditis **(including, but not limited to histoplasmosis induced choroiditis)**
  - ❑ Degenerative idiopathic myopia
  - ❑ Retinal dystrophies
  - ❑ Trauma
  - ❑ Pseudoxanthoma elasticum
  - ❑ Retinopathy of prematurity
  - ❑ Other: _____

❑ **Lucentis®, Byooviz™ or Cimerli™.** 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

- ❑ Which of the following medications is being requested for initial authorization?
  - ❑ Lucentis®
  - ❑ Byooviz™
  - ❑ Cimerli™
- ❑ Provider has submitted member's baseline best corrected visual acuity (BCVA) score: _____
- ❑ Member tried and failed at least 30 days of therapy with Avastin® or bevacizumab
- ❑ Provider has submitted chart notes to document treatment failure with the **PREFERRED** drug
- ❑ Member has been diagnosed with **ONE** of the following labeled indications:
  - ❑ **Lucentis & Cimerli only** - Diabetic macular edema **(DME)**:
    - ❑ Intravitreal Dosing: 0.3 mg once a month
  - ❑ **Lucentis & Cimerli only** - Diabetic retinopathy **(DR)**:
    - ❑ Intravitreal Dosing: 0.3 mg once a month
  - ❑ Neovascular (wet) age-related macular degeneration **(AMD)**:
    - ❑ Intravitreal Dosing: 0.5 mg once a month
  - ❑ Macular edema following retinal vein occlusion **(MEfRVO)**:
    - ❑ Intravitreal Dosing: 0.5 mg once a month
  - ❑ Myopic choroidal neovascularization **(mCNV)**:
    - ❑ Intravitreal Dosing: 0.5 mg once a month for up to 3 months; may re-treat if necessary

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❑ **Lucentis®, Byooviz™ or Cimerli™.** 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.

Reauthorization: based on disease activity assessment

- ❑ Which of the following medications is being requested for reauthorization?
  - ❑ Lucentis®
  - ❑ Byooviz™
  - ❑ Cimerli™
- ❑ Provider has submitted member's BCVA score measured within the last 30 days: _____

❑ **Eylea®, Pavblu™.** 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

- ❑ Which of the following medications is being requested for initial authorization?
  - ❑ Eylea®
  - ❑ Pavblu™
- ❑ Provider has submitted member's baseline best corrected visual acuity (BCVA) score: _____
- ❑ Member tried and failed at least 30 days of therapy with Avastin® or bevacizumab
- ❑ Provider has submitted chart notes to document treatment failure with the **PREFERRED** drug
- ❑ Member has been diagnosed with **ONE** of the following labeled indications:
  - ❑ Neovascular (wet) age-related macular degeneration **(AMD)**:
    - ❑ Intravitreal Dosing: 2 mg (0.05 mL) once every 4 weeks for the first 12 weeks, followed by 2 mg (0.05 mL) once every 8 weeks
  - ❑ Diabetic macular edema **(DME)**:
    - ❑ Intravitreal Dosing: 2 mg (0.05 mL) once every 4 weeks for the first 5 injections, followed by 2 mg (0.05 mL) once every 8 weeks
  - ❑ Diabetic retinopathy **(DR)**:
    - ❑ Baseline Diabetic Retinopathy Disease Severity Scale (DRSS) Level: _____
    - ❑ Intravitreal Dosing: 2 mg (0.05 mL) once every 4 weeks for the first 5 injections, followed by 2 mg (0.05 mL) once every 8 weeks
  - ❑ Macular edema following retinal vein occlusion **(MEfRVO)**:
    - ❑ Intravitreal Dosing: 2 mg (0.05 mL) once every 4 weeks

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❑ **Eylea®, Pavblu™.** 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.

Early Reauthorization: 3 months. Applicable for patients with an insufficient response during initial therapy

- ❑ Provider has submitted progress notes which document patient has experienced an insufficient response to every 8-week dosing as detected by clinical exam, optical coherence tomography or decrease in best corrected visual acuity score and is requesting continuation of therapy at every 4-week dosing

❑ **Eylea®, Pavblu™.** 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.

Reauthorization: based on disease activity assessment

- ❑ Which of the following medications is being requested for initial authorization?
  - ❑ Eylea®
  - ❑ Pavblu™
- ❑ For diagnoses of Neovascular (wet) age-related macular degeneration **(AMD)** or Diabetic macular edema **(DME)**:
  - ❑ Provider has submitted member's BCVA score measured within the last 30 days: _____
  - ❑ If no change in BCVA from baseline:
    - ❑ Maintenance Dose Intravitreal: 2 mg (0.05 mL) once every 8 weeks

    OR
  - ❑ If increase in BCVA or increase presence of intraretinal or sub- retinal fluid or progression of pigment epithelial detachment):
    - ❑ Maintenance Dose Intravitreal: 2 mg (0.05 mL) once every 4 weeks
- ❑ For diagnosis of Diabetic retinopathy (DR):
  - ❑ Provider has submitted member's Diabetic Retinopathy Disease Severity Scale (DRSS) Level recorded within the last 30 days: _____
  - ❑ If DRSS level has decreased from baseline or member's baseline DRSS level was 10:
    - ❑ Maintenance Dose Intravitreal: Intravitreal Dosing: 2 mg (0.05 mL) once every 8 weeks

    OR
  - ❑ If DRSS level has increased from baseline or no change has been observed:
    - ❑ Member does **NOT** have level 10 Disease Severity
    - ❑ Maintenance Dose Intravitreal: Intravitreal Dosing: 2 mg (0.05 mL) once every 4 weeks

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❑ **Eylea® HD.** 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 has submitted member's baseline best corrected visual acuity (BCVA) score: _____
- ❑ Member tried and failed at least 30 days of therapy with Avastin® or bevacizumab **AND** Eylea®
- ❑ Provider has submitted chart notes to document treatment failure with the **PREFERRED** drug
- ❑ Member has been diagnosed with **ONE** of the following labeled indications:
  - ❑ Neovascular (wet) age-related macular degeneration **(AMD)**:
    - ❑ Intravitreal Dosing: 8 mg once every 4 weeks for the first 3 doses, followed by **ONE** of the following (select requested dosing):
      - ❑ 8 mg once every 8 weeks
      - ❑ 8 mg once every 16 weeks
      - ❑ Off-label dose: 8 mg every 4 weeks for 12 doses **(Provider please note: if this dose is selected, it will NOT be approved, please prescribe another medication that is FDA approved for the requested indication)**
  - ❑ Diabetic macular edema **(DME)**:
    - ❑ Intravitreal Dosing: 8 mg once every 4 weeks for the first 3 doses, followed by **ONE** of the following (select requested dosing):
      - ❑ 8 mg once every 8 weeks
      - ❑ 8 mg once every 16 weeks
      - ❑ Off-label dose: 8 mg every 4 weeks for 12 doses **(Provider please note: if this dose is selected, it will NOT be approved, please prescribe another medication that is FDA approved for the requested indication)**
  - ❑ Diabetic retinopathy **(DR)** with and/or without DME:
    - ❑ Baseline Diabetic Retinopathy Disease Severity Scale (DRSS) Level: _____
    - ❑ Intravitreal Dosing: 8 mg once every 4 weeks for the first 3 doses, followed by **ONE** of the following (select requested dosing):
      - ❑ 8 mg once every 8 weeks
      - ❑ 8 mg once every 16 weeks
      - ❑ Off-label dose: 8 mg every 4 weeks for 12 doses **(Provider please note: if this dose is selected, it will NOT be approved, please prescribe another medication that is FDA approved for the requested indication)**

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❑ **Eylea® HD.** 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.

Reauthorization: based on disease activity assessment.

- ❑ For diagnoses of Neovascular (wet) age-related macular degeneration **(AMD)**
  - ❑ Provider has submitted member's BCVA score measured within the last 30 days: _____
  - ❑ Select **ONE** of the following doses based on submission of member's BCVA score:
    - ❑ If no change in BCVA from baseline, maintenance dose intravitreal: 8 mg once every 8 weeks
    - ❑ If BCVA has improved from baseline, maintenance dose intravitreal: 8 mg once every 16 weeks
- ❑ For diagnoses of Diabetic macular edema **(DME)**
  - ❑ Provider has submitted member's BCVA score measured within the last 30 days: _____
  - ❑ Select **ONE** of the following doses based on submission of member's BCVA score:
    - ❑ If no change in BCVA from baseline, maintenance dose intravitreal: 8 mg once every 8 weeks
    - ❑ If BCVA has improved from baseline: maintenance dose intravitreal: 8 mg once every 16 weeks
- ❑ For diagnosis of Diabetic retinopathy **(DR)** with and/or without DME:
  - ❑ Provider has submitted member's Diabetic Retinopathy Disease Severity Scale (DRSS) Level recorded within the last 30 days: _____
  - ❑ Select **ONE** of the following doses based on submission of member's DRSS level
    - ❑ If DRSS level has decreased from baseline or member's baseline DRSS level was 10, maintenance dose intravitreal: 8 mg once every 12 weeks
    - ❑ If DRSS level has increased from baseline or no change has been observed, maintenance dose intravitreal: 8 mg every 8 weeks

❑ **Beovu®.** 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: 3 months

- ❑ Provider has submitted member's baseline best corrected visual acuity (BCVA) score: _____
- ❑ Member tried and failed at least 30 days of therapy with Avastin® or bevacizumab
- ❑ Provider has submitted chart notes to document treatment failure with the **PREFERRED** drug
- ❑ Member has been diagnosed with **ONE** of the following labeled indications:
  - ❑ Neovascular (wet) age-related macular degeneration **(AMD)**
  - ❑ Member has a diagnosis of Diabetic macular edema **(DME)**
    - ❑ First Approval: Initial Dose Intravitreal: 6 mg once per month for 3 months

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❑ **Beovu®.** 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.

Reauthorization: based on disease activity assessment

- ❑ Provider has submitted member's BCVA score measured within the last 30 days: _____
- ❑ Member must meet **ONE** of the following:
  - ❑ Disease activity is present **(defined as loss of < 5 letters in BCVA score)**:
    - ❑ Maintenance Dose Intravitreal: 6 mg once every 8 weeks
  - ❑ No disease activity is present:
    - ❑ Maintenance Dose Intravitreal: 6 mg once every 12 weeks

❑ **Susvimo®.** 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 has submitted member's baseline best corrected visual acuity (BCVA) score: _____
- ❑ Member is 18 years of age or older
- ❑ Member does **NOT** have ocular or periocular infection or active intraocular inflammation or conjunctival scarring
- ❑ Susvimo® will **NOT** be used with other ophthalmic VEGF inhibitors (unless supplemental treatment was approved
- ❑ Member has **NOT** required removal of a Susvimo® implant in the past
- ❑ Member tried and failed at least 30 days of therapy with Avastin® or bevacizumab
- ❑ Provider has submitted chart notes to document treatment failure with the **PREFERRED** drug
- ❑ Member has a diagnosis of **ONE** of the following:
  - ❑ Neovascular (wet) age-related macular degeneration **(AMD)**
    - ❑ Dosing: 2 mg via surgical administration every 6 months. (1 single dose vial per eye per 6 months)
  - ❑ Diabetic Macular Edema **(DME)**
    - ❑ Dosing: 2 mg via surgical administration every 6 months. (1 single dose vial per eye per 6 months)
- ❑ Supplemental treatment to Susvimo® is allowed with Lucentis® only if **ONE** of the following are met:
  - ❑ Decrease in visual acuity by half from the baseline visual acuity
  - ❑ Increase of 150 µm or more in retinal thickness

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❑ **Susvimo™.** 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.

Reauthorization: 12 months (based on disease activity assessment)

- ❑ Medication has **NOT** caused toxicity to the eye (e.g., endophthalmitis, rhegmatogenous retinal detachment, implant dislocation, vitreous hemorrhage, conjunctival erosion, conjunctival retraction, and conjunctival blebs)
- ❑ Member has experienced a beneficial response to therapy (e.g., improvement in the baseline best corrected visual acuity (BCVA), and does not show loss of more than 20 letters in a BCVA (best corrected visual acuity)

❑ **Vabysmo®.** 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: 6 months.

- ❑ Provider has submitted member's baseline best corrected visual acuity (BCVA) score: _____
- ❑ Member tried and failed at least 30 days of therapy with Avastin® or bevacizumab **(submit chart notes to document treatment failure)**
- ❑ Member has been diagnosed with **ONE** of the following labeled indications:
  - ❑ Neovascular (wet) age-related macular degeneration **(AMD)**:
    - ❑ Intravitreal Dosing: 6 mg once every 4 weeks for 4 doses, followed by **ONE** of the following dosing regimens:
      - ❑ Every 16 weeks
      - ❑ Every 12 weeks
      - ❑ Every 8 weeks
  - ❑ Diabetic macular edema **(DME)**:
    - ❑ Intravitreal Dosing: 6 mg once every 4 weeks for 6 doses, followed by 6 mg once every 8 weeks
  - ❑ Macular edema following retinal vein occlusion **(MEfRVO)**
    - ❑ Intravitreal Dosing: 6 mg once every 4 weeks for 6 months
    - ❑ Member has **ONE** of the following types of Retinal Vein Occluison:
      - ❑ Branch retinal vein occlusion (BRVO)
      - ❑ Hemi-retinal vein occlusion (HRVO)
      - ❑ Central retinal vein occlusion (CRVO)
- ❑ Therapy will **NOT** be used with other ophthalmic VEGF inhibitors (e.g., aflibercept, brolucizumab-dbll, ranibizumab, pegaptanib, bevacizumab)

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❑ **Vabysmo®.** 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.

Early Reauthorization: 3 months. Applicable for patients with an insufficient response during initial therapy administered every 4 weeks for at least 4 doses requesting continuation of every 4-week dosing.

- ❑ Provider has submitted progress notes which document patient has experienced an insufficient response to every 4-week dosing as detected by clinical exam, optical coherence tomography or decrease in best corrected visual acuity score

❑ **Vabysmo®.** 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.

Reauthorization: 6 months. Applicable only for patients with a diagnosis of RVO

- ❑ Provider has submitted members' Early Treatment of Diabetic Retinopathy Study (ETDRS) score:
  - ❑ Gain: _____ Loss: _____
- ❑ Provider has submitted member's central subfield thickness (CST) of the macula as measured by optical coherence tomography
  - ❑ Decrease: _____ Stable: _____ Increased: _____
- ❑ Provider will administer requested medication at the following dose:
  - ❑ 6 mg every 4 weeks
  - ❑ 6 mg every _____ weeks **(provider must document requested frequency of administration)**

❑ **Vabysmo®.** 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.

Reauthorization: 12 months (based on disease activity assessment). Applicable for all diagnoses except RVO. Provider Please Note: Patients with loss of response to maintenance therapy administered at less frequent intervals may increase the dosing frequency in a stepwise manner until response is regained.

- ❑ Medication has **NOT** caused toxicity to the eye (e.g., endophthalmitis, rhegmatogenous retinal detachment, implant dislocation, vitreous hemorrhage, conjunctival erosion, conjunctival retraction, and conjunctival blebs)
- ❑ Member has experienced a beneficial response to therapy (e.g., resolution of edema based on the central subfield thickness (CST) of the macula as measured by optical coherence tomography is achieved, improvement in the baseline best corrected visual acuity (BCVA))

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- ❑ Provider will administer requested medication via **ONE** of the following dosing regimens:
  - ❑ Every 16 weeks
  - ❑ Every 12 weeks
  - ❑ Every 8 weeks

Medication being provided by (check applicable box(es) 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.