SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-844-305-2331**. 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**.

Ophthalmic Corticosteroid Injections (MEDICAL)

Drug Requested: (Check box below that applies.)

❑ **Ozurdex®** (dexamethasone intravitreal implant) **(J7312)**	❑ **Iluvien®** (fluocinolone acetonide intravitreal implant) **(J7313)**	❑ **Xipere™** (triamcinolone acetonide injectable suspension) **(C9092)**

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

Member Name: _____

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

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

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

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

❑ 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

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Note: Sentara considers the use of concomitant therapy with Dextenza®, Ozurdex®, Iluvien®, Retisert®, Xipere™, or Yutiq®, to be experimental and investigational. Safety and efficacy of these combinations have NOT been established and will NOT be permitted. In the event a member has an active Dextenza®, Ozurdex®, Iluvien®, Retisert®, Xipere™, or Yutiq® authorization on file, all subsequent requests for an additional ophthalmic corticosteroid injection will NOT be approved.

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.

- ❑ Member was diagnosed with **ONE** of the following:
  - ❑ Macular Edema following branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)
  - ❑ Non-infectious uveitis affecting the posterior segment of the eye
  - ❑ Diabetic Retinopathy
  - ❑ Other: _____

❑ **Ozurdex® (dexamethasone implant) 0.7 mg 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.

1 box of 0.7 mg implant(s) = 7 billable units
NDC: 00023-3348-xx
Quantity Limit: 1 implant (per eye) every 4 months
Max Units (per dose overtime): 7 billable units (per eye) every 4 months
Initial Authorization: 12 months

- ❑ Member has been diagnosed with **ONE** of the following labeled indications
  - ❑ Diabetic macular edema **(DME)**
  - ❑ Macular edema following BRVO or CRVO
- ❑ Member is at least 18 years of age
- ❑ Member does **NOT** have any ocular or periocular infections
- ❑ Member does **NOT** have glaucoma or use medications to treat glaucoma
- ❑ Member does **NOT** have uncontrolled diabetes (A1c > 10%)
- ❑ Medication will **NOT** be used in combination with other sustained-release intravitreal corticosteroids (e.g., fluocinonide acetonide implant)
- ❑ Member's best corrected visual acuity (BCVA) and intraocular pressure are measured at baseline and will be measured periodically during treatment

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- ❑ Baseline best corrected visual acuity (BCVA) measured:_____
- ❑ Member does **NOT** have a history of steroid-induced increased intraocular pressure (IOP > 23 mmHg) in treatment eye(s)
- ❑ Member has a contraindication to bevacizumab intravitreal injection

❑ **Ozurdex® (dexamethasone implant) 0.7 mg 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.

Reauthorization: 12 months

- ❑ Member has **NOT** experienced serious side effects related to toxicity (e.g., increased intraocular pressure, endophthalmitis, conjunctival hemorrhage)
- ❑ Member has **NOT** had a loss of visual acuity from baseline
- ❑ Member does **NOT** have a hypersensitivity to dexamethasone

(❑ **Iluvien® (fluocinonide acetonide implant) 0.19 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.

1 box 0.19 mg implants = 19 billable units

NDC: 68611-0190-xx

Quantity Limit: 1 implant (per eye) every 36 months

Max Units (per dose overtime): 19 billable units (per eye) every 36 months

Initial Authorization: 12 months

- ❑ Member has been diagnosed with Macular edema following BRVO or CRVO
- ❑ Member is at least 18 years of age
- ❑ Member does **NOT** have any ocular or periocular infections
- ❑ Member does **NOT** have glaucoma with a cup to disc ratio > 0.8
- ❑ Member does **NOT** have glaucoma or use medications to treat glaucoma
- ❑ Member does **NOT** have uncontrolled diabetes (A1c > 10%)
- ❑ Medication will **NOT** be used in combination with other sustained-release intravitreal corticosteroids (e.g., fluocinonide acetonide implant)
- ❑ Member's best corrected visual acuity (BCVA) is measured at baseline and will be measured periodically during treatment
- ❑ Baseline best corrected visual acuity (BCVA) measured:_____
- ❑ Member does **NOT** have a history of steroid-induced increased intraocular pressure (IOP > 23 mmHg) in treatment eye(s)

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- ❑ Member has a contraindication to bevacizumab intravitreal injection

❑ **Iluvien® (fluocinonide acetonide implant) 0.19 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.
Reauthorization: 12 months

- ❑ Member has experienced disease response indicated by improvement of best corrected visual acuity (BCVA) score once compared to baseline
- ❑ Member has **NOT** experienced serious side effects related to toxicity (e.g., increased intraocular pressure, endophthalmitis, conjunctival hemorrhage)
- ❑ At least 12 months has passed since last Iluvien® intravitreal injection was administered

❑ **Xipere™ (triamcinolone acetonide injectable suspension).** 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.
1 single dose vial (SDV) = 36 billable units
NDC: 71565-0040-xx
Quantity Limit: 1 vial (per eye) every 12 weeks
Max Units (per dose overtime): 36 billable units (per eye) every 12 weeks
Initial Authorization: 12 months

- ❑ Member is at least 18 years of age
- ❑ Member is free of ocular and periocular infections, including but not limited to, active ocular herpes simplex
- ❑ Member has **NOT** received any of the following sustained-release intravitreal corticosteroids:
  - ❑ Dexamethasone – within the prior 4 months (i.e. Ozurdex®)
  - ❑ Fluocinolone acetonide – within the prior 30 months (Retisert®) or 36 months (Iluvien®, Yutiq®)
- ❑ Member's best corrected visual acuity (BCVA) is measured at baseline and will be measured periodically during treatment
- ❑ Baseline best corrected visual acuity (BCVA) measured: _____
- ❑ Member does **NOT** have untreated intraocular pressure or uncontrolled glaucoma
- ❑ Member has macular edema secondary or related to non-infectious uveitis

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❑ **Xipere™ (triamcinolone acetonide injectable suspension).** 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

- ❑ Member has experienced disease response indicated by improvement of best corrected visual acuity (BCVA) score once compared to baseline
- ❑ Member has **NOT** experienced serious side effects related to toxicity (e.g., increased intraocular pressure, endophthalmitis, conjunctival hemorrhage)
- ❑ At least 4 months has passed since last Xipere™ suprachoroidal injection was administered

Medication being provided by (check box below that applies):

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

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health'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.*

***Approved by Pharmacy and Therapeutics Committee:** 5/19/2022
REVISED/UPDATED: ~~5/7/2022;~~ **8/7/2022**