SENTARA HEALTH PLANS

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 1-844-668-1550**. 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.

Drug Requested: Eylea® (aflibercept) - **Retinopathy of Prematurity (ROP) (J0177) (Medical)**

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.

NOTE: Treatment for this indication is **ONLY** applicable to the single-dose vial kit (NDC: 61755-0005-02). Do **NOT** use the pre-filled syringe for the treatment of ROP.

Recommended Dosage: 0.4 mg (0.01 mL or 10 microliters) administered by intravitreal injection. Treatment may be given bilaterally on the same day. Injections may be repeated in each eye. The treatment interval between doses injected into the same eye should be at least 10 days.

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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: 3 months (for up to 3 injections per eye)

- ❑ Provider is an Ophthalmologist and specializes in the diagnosis of Retinopathy of Prematurity
- ❑ Member has a definitive diagnosis of Retinopathy of Prematurity
- ❑ Member is a premature infant with **ONE** of the following:
  - ❑ Maximum gestational age at birth of ≤ 32 weeks
  - ❑ Birth weight of ≤ 1500 g
- ❑ Provider has submitted infant ROP location & classification according to International Classification ROP (2005) to assess baseline:
  - ❑ Zone I, Stage: _____
  - ❑ Zone II, Stage: _____
  - ❑ Zone III, Stage: _____
  - ❑ Aggressive Posterior Retinopathy of Prematurity (AP-ROP), Zone/Stage: _____
- ❑ Infant does **NOT** have ROP stage 4 or 5

Reauthorization: 3 months (for up to 3 additional injections per eye). 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.

- ❑ Members still has the presence of active ROP and requires continued treatment
- ❑ Provider has submitted current infant ROP location & classification (Zone & Stage) to assess improvement: _____
- ❑ Member has recurrent ROP and requires re-initiation of treatment

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – Proprium Rx**

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