OPTIMA HEALTH 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 1-804-799-5118**. 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 will be delayed.**

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) **(Q5124)**	❑ **Cimerli™** (ranibizumab) **(Q5128)**
❑ **Eylea®** (afliberept **(J0178)**	❑ **Lucentis®** (ranibizumab) **(J2778)**	❑ **Susvimo®** (ranibizumab) **(J2779)**
❑ **Vabysmo®**(faricimab-svoa) **(J2777)**		

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

Member Name: _____

Member Optima #: _____ **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:** _____

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❑ 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

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. **(For Avastin® requests, select member's condition below.)**

❑ Member has been diagnosed with **ONE** of the following:
- ❑ Neovascular (wet) age-related macular degeneration **(AMD)**
- ❑ Diabetic macular edema **(DME)**
- ❑ Diabetic retinopathy **(DR)**
- ❑ Macular edema following retinal vein occlusion **(MEfRVO)**
- ❑ Neovascular glaucoma
- ❑ 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: _____

❑ **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)**

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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.

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

❑ **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®.** 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

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- ❑ 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)** with and/or without DME:
    - ❑ 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

❑ **Eylea®.** 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)** 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) with and/or without DME:
  - ❑ 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

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- ❑ 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

❑ **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

❑ **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: _____

Select **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

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- ❑ 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 tried and failed at least **ONE** of the following:
  - ❑ Eylea®
  - ❑ Beovu®
  - ❑ Lucentis®
  - ❑ Vabysmo®
- ❑ Member has a diagnosis of Neovascular (wet) age-related macular degeneration **(AMD)**
- ❑ Member has experienced disease stability or improvement following at least 2 injections in the same eye of either Beovu®, Eylea®, or Lucentis® prior to Susvimo™ therapy
- ❑ 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

❑ **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
- ❑ 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: 6 mg once every 4 weeks for 4 doses, followed by every 16-week regimen: 6 mg on weeks 28 and 44

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- ❑ Diabetic macular edema **(DME)**:
  - ❑ Intravitreal Dosing: 6 mg once every 4 weeks for 6 doses, followed by 6 mg once every 8 weeks
- ❑ Therapy will **NOT** be used with other ophthalmic VEGF inhibitors (e.g., aflibercept, brolucizumab-dbll, ranibizumab, pegaptanib, bevacizumab)

❑ **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 member's baseline best corrected visual acuity (BCVA) score: _____
- ❑ Provider has submitted progress notes which document patient has experienced an insufficient response to loading dose

❑ **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). 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., 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)

Select **ONE** of the following:

- ❑ Every-16-week regimen:
  - ❑ No Change or improvement in BCVA compared to baseline after initial dosing regimen of every 4 weeks for 4 doses
- ❑ Every-12-week regimen:
  - ❑ Decrease of >5 letters BCVA compared to baseline while on dosing regimen every 16 weeks
- ❑ Every-8-week regimen:
  - ❑ Decrease of >5 letters BCVA compared to baseline while on dosing regimen every 12 weeks

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Medication being provided by a Specialty Pharmacy – Proprium Rx

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

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy - PropriumRx**

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