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 process can be delayed.**

Drug Requested: Visudyne® (verteporfin)

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:** _____

❑ 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.

Recommended Dosage: IV: 6 mg/m^2 BSA; may repeat at 3-month intervals (if evidence of choroidal neovascular leakage)

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

- ❑ Member is 18 years of age or older
- ❑ Prescribed by an Ophthalmologist
- ❑ Member has a diagnosis of subfoveal choroidal neovascularization secondary to age-related macular degeneration, pathologic myopia, or ocular histoplasmosis

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- ❑ Member has tried and failed, has a contraindication or intolerance to bevacizumab (Avastin or biosimilars) **AND** one additional VEGF inhibitor (e.g., Beovu, Eylea, Lucentis, Susvimo, Vabysmo)
- ❑ Provider has documented member's baseline corrected visual acuity measurement (BCVA):

  _____

Reauthorization: 12 months. Check below all that apply. All criteria 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 experienced disease response with treatment as indicated by an improvement in lines of visual acuity from baseline and/or reduction in the number of episodes of severe visual acuity loss
- ❑ Member has **NOT** experienced unacceptable toxicity from the drug (e.g., extravasation, decrease in visual acuity)

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 Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara'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.****