PriorityHealth

Pharmacy
PRIOR AUTHORIZATION FORM

Last Reviewed: April 2012
New: January 2012

For Prior Authorization, please fax toll-free (877) 974-4411, or local number (616) 942-8206

This from applies to: ☐ **Commercial Plan** ☐ **Medicaid Plan** ☒ **Medicare Plan**

Eylea® (aflibercept)

☐ **URGENT** (life threatening)

☐ **Non-Urgent** (standard review)

A claim involving "urgent care" applies when then standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature ____________________ Date ____________________

PRODUCT INFORMATION

NOTE: Eylea™ is a medical benefit (Part B).

☐ Eylea®

Dose: 2mg (0.05ml) ☐ every 28 days for 3 months then every 8 weeks
Start Date: ____________________

BILLING INFORMATION

Place of administration:

☐ Provider's Office
☐ Outpatient facility
Name of facility: ____________________

Billing Options:

☐ Physician buy and bill
☐ Preferred Specialty Vendor
☐ Other: ____________________

PriorityHealth

PRECERTIFICATION REQUIREMENTS

PRIORITY HEALTH PRECERTIFICATION REQUIRMENTS
Authorization for Eylea (aflibercept) requires the following information to certify:

Patient must have met the following requirements:

1. Diagnosis of wet age-related macular degeneration (AMD).

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION
Authorization for Eylea (aflibercept) requires the following information to certify:

A. What is the patient's diagnosis?

☐ Wet, age-related AMD ICD code: ______________________________

☐ Other: ____________________________________ ICD code: ______________________________

Rationale for use: ____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

*** All fields must be complete and legible for Prior Authorization Review***

Please fax this request to: (877)974-4411 toll free or (616)942-8206

YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX