aetna®

MEDICARE FORM

Eylea® (aflibercept) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934 (TTY: 711)

For other lines of business:
Please use other form.

Note: Eylea is non-preferred. The preferred products are bevacizumab (Avastin) first followed by Byooviz. Avastin (C9257) and bevacizumab biosimilars do not require precertification for ophthalmic use.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ **Continuation of therapy, Date of last treatment** ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone: / Work Phone:	Cell Phone:	E-mail:	
Current Weight: ____ lbs or ____ kgs Height: ____ inches or ____ cms	Allergies:		

B. INSURANCE INFORMATION

Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #:

Medicaid: ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:	City:	State:	ZIP:		
Phone: / Fax:	St Lic #:	NPI #:	DEA #:	UPIN:	
Provider Email:	Office Contact Name:	Phone:			

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for Aflibercept (Eylea): Dose: _____ **Directions for Use:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

Primary ICD Code: _____ **Other ICD Code**: _____ **HCPCS Code**: _____

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For *All* Requests: (Supporting documentation ***must*** be provided for review)

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☐ Yes ☐ No Has the patient had prior therapy with Eylea (aflibercept) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to bevacizumab (Avastin)?
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to Byooviz (ranibizumab-nuna)?
☐ Yes ☐ No Is the patient's visual acuity 20/50 or worse?
Please explain if there are any medical reason(s) that the patient cannot use bevacizumab (Avastin): _____
Please explain if there are any medical reason(s) that the patient cannot use Byooviz (ranibizumab-nuna): _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

Please indicate the patient's BCVA prior to initiating treatment: _____/_____ (e.g., 20/320)

☐ Yes ☐ No Is this request for intravitreal injection of the eye? **If yes**, please indicate: ☐ OD (right eye) ☐ OS (left eye) ☐ OU (both eyes)

☐ Yes ☐ No Will aflibercept (Eylea) be given in conjunction with another vascular endothelial growth factor inhibitor?
→ ☐ Yes ☐ No Will the medication be given in the same eye as aflibercept (Eylea)?

☐ Yes ☐ No Does the patient have any of the following contraindications to aflibercept (Eylea)? (check all that apply)
→ ☐ Ocular infection ☐ Periocular infection ☐ Hypersensitivity ☐ Endophthalmitis

Please identify which documented diagnosis the patient is being treated for:

☐ Diabetic Macular edema (including diabetic retinopathy in persons with macular edema)

☐ Macular edema following retinal vein occlusion (RVO) (including central retinal vein occlusion (CRVO) and branch retinal vein occlusion (BRVO))

☐ Myopic choroidal neovascularization (mCNV) ☐ Neovascular (wet) (age related macular degeneration) AMD

For *Continuation* Requests:

Please indicate length of time on aflibercept (Eylea): _____

Please indicate the patient's current BCVA: _____/_____ (e.g., 20/320)

Please choose the best response: ☐ BCVA has improved ☐ BCVA has remained the same
☐ Small vision loss (defined as maximum of 3 lines or 15 letters lost on visual acuity exam)
☐ None of the above

☐ Yes ☐ No Has the patient had improvement in field vision?

☐ Yes ☐ No Has the patient experienced a hypersensitivity reaction to aflibercept (Eylea)?
→ Please indicate which of the following hypersensitivity reactions the patient experienced:
☐ anaphylactoid reactions ☐ pruritus ☐ rash ☐ severe anaphylactic reactions ☐ severe intraocular inflammation
☐ urticaria ☐ Other: please explain: _____

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of aflibercept (Eylea)?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.