

# UPMC HEALTH PLAN

## Eylea and Lucentis Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

### PLEASE TYPE OR PRINT NEATLY

*Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.*

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Qty Dispensed:
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	
Please indicate place of administration: <input type="checkbox"/> Physician Office <input type="checkbox"/> Hospital/facility		Please indicate how medication will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE Provider JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Please provide facility/provider name and address:			

### Medical History

<b>For Lucentis (ranibizumab):</b> Please indicate diagnosis: <input type="checkbox"/> Neovascular (wet) age-related macular degeneration <input type="checkbox"/> Diabetic Macular Edema <input type="checkbox"/> Macular edema following retinal vein occlusion <input type="checkbox"/> Other (please specify): _____	
<b>For Eylea (aflibercept):</b> Please indicate diagnosis: <input type="checkbox"/> Neovascular (wet) age-related macular degeneration <input type="checkbox"/> Macular edema following <u>central</u> retinal vein occlusion <input type="checkbox"/> Other (please specify): _____	
Does the member have an active ocular or periocular infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member have active intraocular inflammation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the provider a retinal specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please provide any additional information which should be considered in the space below:
