



MEDICARE FORM

Lucentis® (ranibizumab),
Byooviz™ (ranibizumab-nuna),
Cimerli™ (ranibizumab-eqrn) Injectable
Medication Precertification Request

Page 1 of 2

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

For Medicare Advantage Part B:
FAX: 1-844-268-7263
PHONE: 1-866-503-0857 (TTY: 711)

For other lines of business:
Please use other form.

Note: Lucentis and Cimerli are non-preferred. The preferred products are bevacizumab (Avastin) first followed by Byooviz or Eylea/Eylea HD. 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

Form section A: Patient Information. Fields include First Name, Last Name, DOB, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, E-mail, Current Weight, Height, and Allergies.

B. INSURANCE INFORMATION

Form section B: Insurance Information. Fields include Aetna Member ID #, Group #, Insured, Medicare status, Medicaid status, and other coverage information.

C. PRESCRIBER INFORMATION

Form section C: Prescriber Information. Fields include First Name, Last Name, Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Provider Email, and Office Contact Name.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Administration Information. Divided into Place of Administration and Dispensing Provider/Pharmacy sections with various checkboxes and text fields.

E. PRODUCT INFORMATION

Form section E: Product Information. Fields include Request is for (Lucentis, Byooviz, Cimerli), Dose, Frequency, and HCPCS code.

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Form section F: Diagnosis Information. Fields include Primary ICD Code, Secondary ICD Code, and Other ICD Code.

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

Form section G: Clinical Information. Includes instructions for Lucentis or Cimerli requests, a note about preferred products, and several questions regarding patient history and medical reasons for not using bevacizumab.

Continued on next page



# MEDICARE FORM

## Lucentis<sup>®</sup> (ranibizumab), Byooviz<sup>™</sup> (ranibizumab-nuna), Cimerli<sup>™</sup> (ranibizumab-eqrn) Injectable Medication Precertification Request

Page 2 of 2

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FAX: [1-844-268-7263](tel:1-844-268-7263)  
PHONE: [1-866-503-0857](tel:1-866-503-0857) (TTY: [711](tel:711))

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Please use other form.

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION (continued)** – Required clinical information must be completed in its entirety for all precertification requests.

**For Byooviz Requests: (clinical documentation required for all requests)**

**Note: Bevacizumab (Avastin) is preferred first prior to Byooviz. Avastin (C9257) and bevacizumab biosimilars do not require precertification for ophthalmic use.**

- Yes  No Has the patient had prior therapy with Byooviz (ranibizumab-nuna) within the last 365 days?
  - Yes  No Has the patient had a trial and failure, intolerance, or contraindication to bevacizumab (Avastin)?
- Please explain if there are any other medical reason(s) that the patient cannot use bevacizumab (Avastin).

What is the patient's BCVA (best corrected visual acuity) prior to initiating treatment: \_\_\_\_ / \_\_\_\_ (e.g., 20/320)

- Yes  No Is this request for intravitreal injection of the eye?  
     ↳ Please indicate which eye:  OD (right eye)  OS (left eye)  OU (both eyes)
- Yes  No Will Lucentis (ranibizumab) be given in conjunction with another vascular endothelial growth factor inhibitor?  
     ↳  Yes  No Will the medication be given in the same eye as Lucentis (ranibizumab)?
- Yes  No Does the patient have any of the following contraindications to Lucentis (ranibizumab)? (check all that apply)  
     ↳  Endophthalmitis  Ocular infection  Periocular infection  Hypersensitivity

- Please identify which documented diagnosis the patient is being treated for:
- Diabetic retinopathy  Diabetic macular edema  Macular edema following retinal vein occlusion (RVO)  Polypoidal choroidal vasculopathy
  - Myopic Choroidal Neovascularization (mCNV)  Neovascular (wet) (age related macular degeneration) AMD  Neovascular glaucoma
  - Pseudoxanthoma elasticum  
     ↳  Yes  No Is this a request for re-treatment?
  - Rare causes of choroidal neovascularization  
     ↳ Please identify the cause of choroidal neovascularization:  
          Angioid streaks  Choroiditis (including choroiditis secondary to ocular histoplasmosis)  Idiopathic degenerative myopia  
          Retinal dystrophies  Rubeosis iridis  Trauma  Other: Please identify: \_\_\_\_\_  
          Yes  No Is this a request for re-treatment?  
             ↳ What is the length of treatment being requested?  3 months or less  Greater than 3 months
  - Retinopathy of prematurity  
     ↳ Please indicate the stage of disease:  Stage 1  Stage 2  Stage 3  Stage 4  Stage 5

**For Continuation Requests:**

- Please indicate length of time on Lucentis (ranibizumab), Byooviz (ranibizumab-nuna), or Cimerli (ranibizumab-eqrn): \_\_\_\_\_
- Please indicate the patient's current BCVA: \_\_\_\_ / \_\_\_\_ (e.g., 20/320)
- Please choose the patient 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 Lucentis (ranibizumab), Byooviz (ranibizumab-nuna), or Cimerli (ranibizumab-eqrn)?  
     ↳ 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 Lucentis (ranibizumab), Byooviz (ranibizumab-nuna), or Cimerli (ranibizumab-eqrn)?

**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.