



MEDICARE FORM

SUSVIMO™ (ranibizumab) 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: Susvimo is 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, Allergies.

B. INSURANCE INFORMATION

Form section B: Insurance Information. Fields include Member ID #, Group #, Insured, Does patient have other coverage?, Carrier Name, Medicare, Medicaid.

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 E-mail, Office Contact Name, Phone.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Administration Information. Divided into Place of Administration and Dispensing Provider/Pharmacy. Includes fields for Self-administered, Physician's Office, Outpatient Infusion Center, Home Infusion Center, Administration code(s), and various pharmacy details like Name, Address, City, State, ZIP, Phone, FAX, TIN, PIN, NPI.

E. PRODUCT INFORMATION

Form section E: Product Information. Fields include Request is for: SUSVIMO (ranibizumab), Dose, Frequency, HCPCS code.

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

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

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

Form section G: Clinical Information. Includes For Initiation Requests (clinical documentation required for all requests), Note: Susvimo is non-preferred, and questions about prior therapy and medical reasons for not using bevacizumab or Byooviz/Eylea HD.

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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.

**Neovascular (wet) age-related macular degeneration (AMD)**

- Yes  No Has the patient previously responded to at least two intravitreal injections of a Vascular Endothelial Growth Factor (VEGF) inhibitor (e.g., Avastin, Eylea) within the past 6 months?
- Yes  No Will the requested medication be used in conjunction with Susvimo ocular implant?

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

- Yes  No Has the patient demonstrated a positive clinical response to therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss)?

**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.