



MEDICARE FORM

VABYSMO™ (faricimab-svoa) 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: Vabysmo 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, and Allergies.

B. INSURANCE INFORMATION

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

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, Office Contact Name, and Specialty.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Administration Information. Divided into Place of Administration and Dispensing Provider/Pharmacy details.

E. PRODUCT INFORMATION

Form section E: Product Information. Fields include Request is for (VABYSMO), Dose, Frequency, and 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 and Other ICD Code.

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

Form section G: Clinical Information. Includes initiation request requirements, a note about preferred products, and questions regarding patient history and medical reasons for not using bevacizumab.

Continued on next page



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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.**

**Please select the diagnosis:**

- Diabetic macular edema
- Neovascular (wet) age-related macular degeneration (AMD)

**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.