



Beovu® (brolucizumab-dbl) Injectable Medication Precertification Request

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

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

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:			
Address:			City:		State:
Home Phone:			Work Phone:		Cell Phone:
DOB:	Allergies:				E-mail:
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms			

B. INSURANCE INFORMATION

Member ID #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Group #:	If yes, provide ID#: _____ Carrier Name: _____				
Insured:	Insured: _____				
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:			Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:		

C. PRESCRIBER INFORMATION

First Name:		Last Name:				(Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:		
Provider E-mail:			Office Contact Name:			Phone:	
Specialty (Check one): <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Other: _____							

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: (Patient selected choice)			
<input type="checkbox"/> Self-administered	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Physician's Office		<input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Outpatient Infusion Center	Phone: _____	<input type="checkbox"/> Specialty Pharmacy		<input type="checkbox"/> Other: _____	
Center Name: _____		Name: _____			
<input type="checkbox"/> Home Infusion Center	Phone: _____	Address: _____			
Agency Name: _____		Phone: _____ FAX: _____			
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ PIN: _____			
Address: _____					

E. PRODUCT INFORMATION

Request is for Beovu (brolucizumab-dbl) 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: _____

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

For Initiation Requests (clinical documentation required for all requests):

Please select the diagnosis:

Diabetic Macular Edema

Neovascular (wet) age related macular degeneration

Other: _____

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.