



Eylea-Eylea HD[®] and Biosimilars 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 (TTY: 711)**
FAX: **1-888-267-3277**

For Medicare Advantage Part B:
Please Use Medicare Request Form

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:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone: Email:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms				Allergies:	

B. INSURANCE INFORMATION

Aetna 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 Email:			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: Eylea (afibercept) Eylea HD (afibercept) Opuviz (afibercept-yszy) Yesafili (afibercept-jbvf)

Dose: _____ Frequency: _____

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

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

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

For Eylea, Opuviz or Yesafili Requests (clinical documentation required):

Please select the diagnosis:

Diabetic Macular Edema
 Diabetic Retinopathy
 Macular Edema Following Retinal Vein Occlusion
 Neovascular (Wet) Age Related Macular Degeneration
 Retinopathy of Prematurity
 Other: _____

Yes No Has the patient had an ineffective response, contraindication or intolerance to Avastin?
 Yes No Has the patient had an ineffective response, contraindication or intolerance to Byooviz OR Cimerli?

For Eylea HD Requests (clinical documentation required):

Please select the diagnosis:

Diabetic Macular Edema
 Diabetic Retinopathy
 Neovascular (Wet) Age-Related Macular Degeneration
 Other: _____

Yes No Has the patient had an ineffective response, contraindication or intolerance to Avastin?
 Yes No Has the patient had an ineffective response, contraindication or intolerance to Byooviz OR Cimerli?

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FAX: [1-888-267-3277](tel:1-888-267-3277)

For Medicare Advantage Part B:

Please Use Medicare Request Form

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 ALL Continuation Requests (clinical documentation required):

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.