



## MEDICARE FORM

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

Page 1 of 4

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

For Medicare Advantage Part B:  
For other lines of business:  
Please use commercial form.

Note: Lucentis and Cimerli are non-preferred. The preferred products are bevacizumab (Avastin) first followed by Byooviz or Eylea/Eylea HD. Bevacizumab (C9257) does not require precertification for ophthalmic use.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to:

**Phone:** [1-866-503-0857](tel:1-866-503-0857) (TTY: [711](tel:1-866-503-0857))

**Fax:** [1-844-268-7263](tel:1-844-268-7263)

**Availity:** <https://www.aetna.com/health-care-professionals/resource-center/availability.html>

For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:

**Phone:** [1-855-463-0933](tel:1-855-463-0933)

**Fax:** [1-833-280-5224](tel:1-833-280-5224)

**Availity:** <https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal>

For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:

**Phone:** [1-844-362-0934](tel:1-844-362-0934)

**Fax:** [1-833-322-0034](tel:1-833-322-0034)

**Availity:** <https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html>

For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to:

**Phone:** [1-866-600-2139](tel:1-866-600-2139)

**FAX:** [1-855-320-8445](tel:1-855-320-8445)

**Availity:** <https://www.aetnabetterhealth.com/illinois/providers/portal>

For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to:

**Phone:** [1-855-364-0974](tel:1-855-364-0974)

**Fax:** [1-855-734-9389](tel:1-855-734-9389)

**Availity:** <https://www.aetnabetterhealth.com/ohio/providers/portal>

For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to:

**Phone:** [1-855-676-5772](tel:1-855-676-5772)

**Fax:** [1-844-241-2495](tel:1-844-241-2495)

**Availity:** <https://www.aetnabetterhealth.com/michigan/providers/portal.html>



MEDICARE FORM

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Byooviz™ (ranibizumab-nuna),
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Medication Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Lucentis and Cimerli are non-preferred. The preferred products are bevacizumab (Avastin) first followed by Byooviz or Eylea/Eylea HD. Bevacizumab (C9257) does 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 containing fields for Patient Information: 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 containing fields for Insurance Information: Aetna Member ID #, Group #, Insured, Medicare status, Medicaid status, and other coverage details.

C. PRESCRIBER INFORMATION

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

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D containing fields for Dispensing Provider/Pharmacy: Place of Administration (Self-administered, Physician's Office, Outpatient Infusion Center, Home Infusion Center, Administration code(s)), and Dispensing Provider/Pharmacy details (Physician's Office, Retail Pharmacy, Specialty Pharmacy, Mail Order, Other, Name, Address, City, State, ZIP, Phone, Fax, TIN, PIN, NPI).

E. PRODUCT INFORMATION

Form section E containing fields for Product Information: 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 containing fields for Diagnosis Information: 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 containing clinical information for Lucentis or Cimerli requests, including a note on preferred products and questions about prior therapy and adverse reactions to bevacizumab.

Continued on next page



# MEDICARE FORM

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

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

For Medicare Advantage Part B:  
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Please use commercial 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 Lucentis or Cimerli Requests: (clinical documentation required for all requests)**

- No Has the patient had a trial and failure of any of the following? (if yes, select all that apply below)
  - Byooviz (ranibizumab-nuna)  Eylea/Eylea HD (afibercept)
  - When was the member's trial and failure of the preferred drug? \_\_\_\_\_
  - Please describe the nature of the failure of the preferred drug \_\_\_\_\_
- No Has the patient had an adverse reaction to any of the following? (if yes, select all that apply below)
  - Byooviz (ranibizumab-nuna)  Eylea/Eylea HD (afibercept)
  - When was the member's adverse reaction to the preferred drug? \_\_\_\_\_
  - Please describe the nature of the adverse reaction to the preferred drug \_\_\_\_\_

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use bevacizumab (Avastin).

Please explain if there are any contraindications or any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)

- Byooviz (ranibizumab-nuna)  Eylea/Eylea HD (afibercept)

**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 of bevacizumab (Avastin)?
  - When was the member's trial and failure of bevacizumab (Avastin)? \_\_\_\_\_
  - Please describe the nature of the failure of bevacizumab (Avastin) \_\_\_\_\_
- Yes  No Has the patient had an adverse reaction to bevacizumab (Avastin)?
  - When was the member's adverse reaction to bevacizumab (Avastin)? \_\_\_\_\_
  - Please describe the nature of the adverse reaction to bevacizumab (Avastin) \_\_\_\_\_

Please explain if there are any contraindications or 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

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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 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.