MEDICARE FORM

SUSVIMO™ (ranibizumab) Injectable Medication Precertification Request

(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: Susvimo is 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 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 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 **Fax:** 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 **FAX:** 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 **Fax:** 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 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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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:	E-mail:
Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms		Allergies:	

B. INSURANCE INFORMATION

Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:	Last Name:			*(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Ophthalmologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ FAX: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

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 (*).

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):

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

☐ Yes ☐ No Has the patient had prior therapy with Susvimo (ranibizumab) 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) _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests *continued* (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 (aflibercept)
- → 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 (aflibercept)
- → 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 other medical reason(s) that the patient cannot use Byooviz (ranibizumab-nuna) or Eylea/Eylea HD (aflibercept) when indicated for the patient's diagnosis.

_____

_____

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.