MEDICARE FORM
Eylea® (aflibercept), Eylea® HD (aflibercept) 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: Eylea and Eylea HD are non-preferred. The preferred product is bevacizumab (Avastin). Avastin (C9257) and bevacizumab biosimilars do 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

aetna®

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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 Email:	Office Contact Name:		Phone:		

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:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Eylea** ☐ **Eylea HD** **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**: _____ **HCPCS Code**: _____

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

For *All* Requests: (Supporting documentation ***must*** be provided for review)

Note: Eylea and Eylea HD are non-preferred. The preferred product is bevacizumab (Avastin). Avastin (C9257), and bevacizumab biosimilars do not require precertification for ophthalmic use.

☐ Yes ☐ No Has the patient had prior therapy with the requested product 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) _____
☐ Yes ☐ No Is the patient's visual acuity 20/50 or worse?
Please explain if there are any contraindications or other medical reason(s) that the patient cannot use bevacizumab (Avastin):
_____

Continued on next page

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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.

Please indicate the patient's BCVA prior to initiating treatment: _____/_____ (e.g., 20/320)

☐ Yes ☐ No Is this request for intravitreal injection of the eye? **If yes**, please indicate: ☐ OD (right eye) ☐ OS (left eye) ☐ OU (both eyes)

☐ Yes ☐ No Will aflibercept (Eylea) be given in conjunction with another vascular endothelial growth factor inhibitor?

→ ☐ Yes ☐ No Will the medication be given in the same eye as aflibercept (Eylea)?

☐ Yes ☐ No Does the patient have any of the following contraindications to aflibercept (Eylea)? (check all that apply)

→ ☐ Ocular infection ☐ Periocular infection ☐ Hypersensitivity ☐ Endophthalmitis

Please identify which documented diagnosis the patient is being treated for:

☐ Diabetic Macular edema (including diabetic retinopathy in persons with macular edema)

☐ Macular edema following retinal vein occlusion (RVO) (including central retinal vein occlusion (CRVO) and branch retinal vein occlusion (BRVO))

☐ Myopic choroidal neovascularization (mCNV) ☐ Neovascular (wet) (age related macular degeneration) AMD

For *Continuation* Requests:

Please indicate length of time on aflibercept (Eylea): _____

Please indicate the patient's current BCVA: _____/_____ (e.g., 20/320)

Please choose the best 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 aflibercept (Eylea)?

→ 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 aflibercept (Eylea)?

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.