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

(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:	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: ______________

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

E. PRODUCT INFORMATION

Request is for: ☐ **Lucentis (ranibizumab)** ☐ **Byooviz (ranibizumab-nuna)** ☐ **Cimerli (ranibizumab-eqrn)**
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 All Requests (clinical documentation required for all requests):

Please select the diagnosis:
☐ Diabetic macular edema
☐ Diabetic retinopathy
☐ Macular edema following retinal vein occlusion
☐ Myopic choroidal neovascularization
☐ Neovascular (wet) age- related macular degeneration

For Lucentis Requests Only:
☐ 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 Byooviz and Cimerli Requests Only:
☐ Yes ☐ No Has the patient had an ineffective response, contraindication or intolerance to Avastin?

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)?

Continued on next page

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

(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

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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.