UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Anti-Vascular Endothelial Growth Factor Therapy

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval (all criteria must be met and documented in submitted chart notes):

- ❑ Medication is prescribed by or in consultation with a physician who specializes in the disease treatment.
- ❑ Documentation of FDA-approved or compendia-recommended diagnosis: _____
  Chart Note Page #: _____
- ❑ Trial and failure of guideline recommended first line treatment or the clinical rationale for the lack thereof, if appropriate. Chart note page #: _____
- ❑ Use must follow FDA-approved label dosing and monitoring *(including monitoring for boxed warnings and contraindications).*
  - Applicable monitoring for boxed warnings. Chart Note Page #: _____

Susvimo additional criteria:

- ❑ Documentation of response to 2 or more previous intravitreal injections of a vascular endothelial growth factor inhibitor medication within the six months prior to this implantation:
  Drug: _____ Injection Date: _____ Drug: _____ Injection Date: _____
  Response: _____ Response: _____

Off Label or Compendia Use Additional Criteria:

- ❑ Requests for any off-label indications must be supported by at least one (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet or other peer review specialty medical journals within the most recent five

(5) years. Supporting documentation must be included. Compendia use must be recommended by generally-accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), and the DRUGDEX Information System.
Diagnosis: _____
Duration of treatment: _____

Biosimilar Criteria: *Use consistent with the National Comprehensive Cancer Network (NCCN) recommendations.*
Indication for biosimilar use: _____ Chart Note Page #: _____

Re-authorization Criteria:
Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.

Note:

- Use appropriate HCPCS code for billing
  Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

Initial Authorization: Up to one (1) year
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date