# Luxturna (Voretigene neparvovec)

| Member and Medication Information<br>* 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**<br>* indicates required field | |
| *Requesting Provider Name: | *NPI: |
| *Address: | |
| *Contact Person: | *Phone #: |
| *Fax #: | Email: |
| **Medically Billed Information**<br>* 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:** *(at least one of the following criteria must be met)*

- ❑ Prescribed by an ophthalmologist, specializing in the care of patients with retinal dystrophy
- ❑ The patient has confirmed diagnosis of Biallelic RPE65 mutation-associated retinal dystrophy as confirmed by genetic testing
- ❑ The provider confirmed that the patient has viable retinal cells
- ❑ Which eye is being treated?
  - ❑ Left eye
  - ❑ Right eye
  - ❑ Both eyes, which will be treated separately at least 6 days apart
- ❑ Has the patient received Luxturna previously?
  - ❑ Yes – the eye(s) were previous treated: _______________
  - ❑ No
- ❑ Provider attests to complete all post-infusion monitoring described in the current Luxturna prescribing information.

**Initial Authorization:** One (1) treatment per eye per lifetime
**Re-authorization:** None

**Note:**

- ❖ Use appropriate HCPCS codes 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

## PROVIDER CERTIFICATION

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

________________________________________ ________________

Prescriber’s Signature Date