UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Ophthalmic Corticosteroid Intravitreal Implants/Injections (Iluvien, Ozurdex, Retisert, Triesence, Xipere, Yutiq)

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.*

- ❑ Implant or injection is prescribed and administered by an ophthalmologist.
- ❑ Patient is at least 18 years of age (or 12 years of age for Retisert).
- ❑ Patient doesn't have contraindicated conditions of the requested medication per prescribing information.

Iluvien (fluocinolone acetonide 0.19 mg) Additional Criteria: *All Criteria must be met.*

- ❑ Diagnosis of Diabetic Macular Edema (DME).
- ❑ Previously treated with a course of ophthalmic corticosteroids, without a clinically significant rise in intraocular pressure.
  Medication and dose: _____
  Duration of use: _____ Chart Note Page #: _____
- ❑ Previously undergone at least one prior macular laser photocoagulation treatment.
- ❑ Evidence of anti-VEGF failure or suboptimal response after 24 weeks (6 months)

Ozurdex (dexamethasone 0.7 mg) Additional Criteria: *All Criteria must be met.*

- ❑ Diagnosis of one of the following:
  - ○ Diabetic Macular Edema (DME).
  - ○ Macular Edema following branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO).
    - Evidence of anti-VEGF failure or suboptimal response after 24 weeks (6 months)

- ○ Non-Infectious Uveitis affecting the posterior segment of the eye.
  - ☐ Trial and failure of Humira (adalimumab) for at least 6 weeks within last year.
    Duration of use: _____ Chart Note Page #: _____
    Details of Failure: _____

Retisert (fluocinolone acetonide 0.59 mg) Additional Criteria: *All Criteria must be met.*

- ❑ Diagnosis of chronic (one year or greater) non-infectious uveitis affecting the posterior segment of the eye.
- ❑ Trial and failure of Humira (adalimumab) for at least 6 weeks within last year.
  Duration of use: _____ Chart Note Page #: _____
  Details of Failure: _____

Triesence (triamcinolone acetonide injectable suspension) Additional Criteria: *All Criteria must be met.*

- ❑ Diagnosis of one of the following:
  - ○ Visualization during vitrectomy
  - ○ Sympathetic ophthalmia
  - ○ Temporal arteritis
  - ○ Uveitis
  - ○ Ocular inflammatory conditions unresponsive to ophthalmic corticosteroids.
    - ☐ Trial and failure of ophthalmic corticosteroid.
      Medication and dose: _____
      Duration of use: _____ Chart Note Page #: _____

Xipere (triamcinolone acetonide injectable suspension) Additional Criteria: *All Criterion must be met.*

- ❑ Indication for the treatment of macular edema associated with uveitis.
- ❑ Trial and failure of Humira (adalimumab) for at least 6 weeks within last year.
  Duration of use: _____ Chart Note Page #: _____
  Details of Failure: _____

Yutiq (fluocinolone acetonide 0.18 mg) Additional Criteria: *All Criteria must be met.*

- ❑ Diagnosis of Chronic Non-Infectious Uveitis affecting the posterior segment of the eye.
- ❑ Trial and failure of Humira (adalimumab) for at least 6 weeks within last year.
  Duration of use: _____ Chart Note Page #: _____
  Details of Failure: _____

Authorization: One implant per approval; injection number to be determined on individual case review.
Reauthorization: Permitted for opposite eye if treatment of the first eye is successful.

PROVIDER CERTIFICATION

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

_____ _____
Prescriber's Signature Date