pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

MACULAR DEGENERATION AGENTS PRIOR AUTHORIZATION FORM

- To review the prior authorization guidelines for Macular Degeneration Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Macular Degeneration Agents** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to Quantity Limits list at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request ☐Additional info (PA# _____)	# of pages in request: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: *(all agents require prior authorization; NP = non-preferred agent)*			☐Eylea	☐Lucentis ☐Macugen **(NP)**
Strength:	Eye(s) to be treated:	☐right eye ☐left eye ☐both eyes	Frequency: every _____ weeks / month(s)	Requested duration:
Macular Degeneration Agents are part of the Department's Specialty Pharmacy Drug Program (SPDP). Which specialty pharmacy will be used?			☐Diplomat Specialty Pharmacy ☐Walgreens Specialty Pharmacy	

Section A: Initial requests	
1. Does the Recipient have one of the following diagnoses? ☐diabetic macular edema ☐diabetic retinopathy with diabetic macular edema ☐macular edema following retinal vein occlusion (RVO) ☐neovascular (wet) age-related macular degeneration (AMD)	☐Yes – *submit medical record documentation supporting diagnosis* ☐No – *submit documentation of medical literature supporting the use of the requested agent for the Recipient's diagnosis*
2. What is the corresponding diagnosis code for the Recipient's diagnosis?	Dx code *(required)*: _____
3. *For the non-preferred agent, Macugen*, has the Recipient tried and failed, or have a contraindication or intolerance to, the following preferred Macular Degeneration Agents? ☐Eylea ☐Lucentis	☐Yes – *submit all supporting documentation of drug regimen and treatment outcome* ☐No or not applicable
4. *For a diagnosis of neovascular (wet) age-related macular degeneration*, has the Recipient tried and failed, or have a contraindication or intolerance to, intravitreal bevacizumab?	☐Yes – *submit all supporting documentation of bevacizumab regimen and treatment outcome* ☐No
Section B: Renewal requests	
1. Does the Recipient have documented improvement or stabilization of visual acuity since starting treatment with the requested agent?	☐Yes ☐No *Submit medical record documentation of Recipient's response to treatment*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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