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	Total # pages: ________	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)** ☐Visudyne
Strength:	**Formulation:** ☐vial ☐syringe ☐__________________	**Frequency:**
Eye(s) to be treated:	☐right eye ☐left eye ☐both eyes ☐__________________	**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

Initial request	
1. Does the Recipient have one of the following diagnoses? *Check recipient's diagnosis.* ☐diabetic macular edema ☐diabetic retinopathy → ☐with diabetic macular edema ☐without diabetic macular edema ☐macular edema following retinal vein occlusion (RVO) ☐myopic choroidal neovascularization ☐neovascular (wet) age-related macular degeneration (AMD) ☐subfoveal choroidal neovascularization (predominantly classical)	☐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
Renewal request	
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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