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

Prior authorization guidelines for **Macular Degeneration Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	NPI:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

Medication requested: *(all agents require prior authorization)*	☐Eylea ☐Lucentis	☐Macugen ☐Visudyne	☐_____		
Strength:	Formulation:	☐vial	☐syringe	☐_____	Frequency:
Eye(s) to be treated:	☐right eye	☐left eye	☐both eyes	☐_____	Requested duration:

INITIAL requests

Does the beneficiary have one of the following diagnoses? *Indicate beneficiary'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 beneficiary's diagnosis.*
What is the corresponding diagnosis code for the beneficiary's diagnosis?	Dx code *(required)*: _____
Has the beneficiary tried and failed or have a contraindication or intolerance to intravitreal bevacizumab?	☐Yes – *Submit all supporting documentation of bevacizumab regimen and treatment outcome.* ☐No ☐Not clinically appropriate
For a non-preferred medication: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents in this class that are approved or medically accepted for the beneficiary's diagnosis?	☐Yes ☐No *Submit documentation.*

RENEWAL requests

List previous doses of the requested medication:

Right eye: _____

Left eye: _____

Has the beneficiary experienced a positive clinical response to previously administered doses of the requested medication?	☐Yes ☐No *Submit medical record documentation of beneficiary's response to treatment.*

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

Prescriber Signature:	**Date**: