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## AFLIBERCEPT OPHTHALMIC PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:			
<b>RECEIPIENT INFORMATION</b>			
Medicaid ID:	Date of Birth:	Sex:	M      F
Last Name:		First Name:	
<b>GENERAL INFORMATION</b>			
First Date of Service:		Last Date of Service:	
Primary Diagnosis Code:		HCPC Code:	
Drug Name:	Dose & Frequency:	Requested Eye: R      L	
Hospitalizations/Treatments/Medications Used in the last 6 months:			
<b>POINT OF CONTACT</b>			
Name and Title:			
Email:	Phone:	Fax:	
<small><i>Note: The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.</i></small>			
<b>REFERRING PROVIDER INFORMATION</b>			
Name:			
NPI #:		Taxonomy:	
Phone:		Fax:	
<b>SERVICING PROVIDER INFORMATION</b>			
Name:			
Address:			
NPI #:		Taxonomy:	
Phone:		Fax:	

<b>CRITERIA</b>		
<b>Medical records to support use of product are submitted</b>		
<b>Initial Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
Therapy is prescribed by or in consultation with an ophthalmologist		
Individual has a diagnosis of <b>one</b> of the following: <ul style="list-style-type: none"> <li>• Diabetic macular edema</li> <li>• Diabetic retinopathy</li> <li>• Macular edema following retinal vein occlusion</li> <li>• Age-related macular degeneration</li> </ul>		
Individual has a documented best corrected visual acuity (BCVA) score of 20/40 or worse within the last 12 months		
Individual has failed therapy (≥90 days) with intravitreal bevacizumab		
Individual is ≥18 years of age		
<b>Continuation of Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
Documentation is submitted indicating positive response to therapy as demonstrated by a maintained or improved BCVA score		
<b>PHYSICIAN SIGNATURE – PROVIDER ONLY</b>		
This form <u>must be</u> signed by a provider		
I certify that the information given in this form is a true and accurate medical indication for the required product		
<b>Name &amp; Title (Printed):</b>		<b>Specialty:</b>
<b>Signature:</b>		