AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Noninfectious Uveitis (NIU) Drugs (MEDICAL)

Drug Requested: (Check box below that applies)

❑ **Retisert®** (fluocinolone acetonide intravitreal implant, 0.59 mg) **(J7311)** • 1 package: 0.59 mg implant = 59 billable units every 30 months • Quantity Limit: 2 implants every 30 months (1 implant per eye) • Max Units (per dose): 118 billable units per 30 months	❑ **Yutiq®** (fluocinolone acetonide intravitreal implant, 0.18 mg) **(J7314)** • 1 package: 0.18 mg implant = 18 billable units every 36 months • Quantity Limit: 2 implants every 36 months (1 implant per eye) • Max Units (per dose): 36 billable units every 36 months

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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❑ Left Eye ❑ Right Eye ❑ Both Eyes

Note: AvMed considers the use of concomitant therapy with Dextenza®, Ozurdex®, Iluvien®, Retisert®, Xipere™, or Yutiq®, to be experimental and investigational. Safety and efficacy of these combinations have NOT been established and will NOT be permitted. In the event a member has an active Dextenza®, Ozurdex®, Iluvien®, Retisert®, Xipere™, or Yutiq® authorization on file, all subsequent requests for an additional ophthalmic corticosteroid injection will NOT be approved.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

SECTION A:		
Slit lamp examination used to make diagnosis?	❑ Yes	❑ No
Intraocular pressure (IOP) measurement taken at baseline? Baseline IOP results: _____	❑ Yes	❑ No
Visual Acuity Test results: _____		
Labs and documentation to rule out infectious etiology	❑ Yes	❑ No
Anterior Chamber cells present?	❑ Yes	❑ No

NON-INFECTIOUS UVEITIS (NIU): (Please submit supporting document to questions below)

Initial Authorization: 30 months (Retisert®) or 36 months (Yutiq®)

Please note member's diagnosis. **NOTE: If member is only diagnosed with Anterior Uveitis additional comorbidities including etiology will be required for approval**

❑ Anterior Uveitis	❑ Intermediate Uveitis	❑ Posterior Uveitis	❑ Pan Uveitis

Is this member positive for HLA-B27 antigen?	❑ Yes	❑ No
Please include other diagnosis that contributes to Anterior Uveitis **ONLY** diagnosis: _____ _____		

- ❑ Completed **SECTION A**
- ❑ Diagnosis of chronic (1+ years) non-infectious uveitis affecting the posterior segment of the eye
- ❑ Diagnosis and disease progression confirmed/determined by fluorescein angiography, Optical Coherence Tomography (OCT) or Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

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PAID CLAIMS MUST MATCH STATEMENT BELOW:

- ❑ Member must have inadequate response (i.e. recurrent uveitis despite use of traditional therapy), clinically significant adverse effects associated with high dose systemic steroid or immunosuppressive therapy, labeled contraindication, or clinical rationale supporting the inappropriateness of the following, include date(s) of failed therapy or clinical event(s). **Documentation required.**
- ❑ Member must meet at least **ONE** of the following:
  - ❑ Tried and failed maximized topical or systemic steroid treatment for **at least 4 weeks** resulting in ineffective therapy. **Check ALL that apply**:

❑ Dexamethasone	❑ difluprednate (Durezol®)	❑ fluoromethalone (FML®)
❑ loteprednol (Lotemax®)	❑ Oral prednisone or equivalent	❑ prednisolone acetate (Pred Forte®)

  Name, dose and dates of the equivalent high does steroid trials: _____

  _____

  - ❑ Tried and failed at least **ONE** immunosuppressive agent of 3 months due to toxicity **OR** failure to stabilize disease. **(Submit supporting documentation of toxicities and progression, include labs - CBC, BUN, SCr, AST, ALT and albumin). Check ALL that apply**:

❑ Adalimumab	❑ Azathioprine	❑ Cyclosporine or tacrolimus	❑ Infliximab
❑ Etanercept	❑ Golimumab	❑ Methotrexate	❑ Mycophenolate
❑ Rituximab	❑ Tocilizumab		

  - ❑ Member has received at least **TWO** administration or intra- or peri-ocular corticosteroid injections
  - ❑ Member has received at least **TWO** separate recurrences of uveitis requiring treatment with systemic corticosteroids or ocular injections of corticosteroids
- ❑ Medication is being prescribed by a board-certified ophthalmologist or retinal specialist experienced in administration of intravitreal injections
- ❑ Member will **NOT** be administered intravitreal implant simultaneously or with other intravitreal implants at the same time
- ❑ Member does **NOT** have any of the following contraindications/exclusions to either therapy:
  - ❑ Hypersensitivity to fluocinolone or any of its components
  - ❑ Ocular or periocular infection
  - ❑ Advanced glaucoma
  - ❑ Concurrent intravitreal implants

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NON-INFECTIOUS UVEITIS (NIU): (Please submit supporting document to questions below)

Reauthorization: 30 months (Retisert®) or 36 months (Yutiq®)

- ❑ Member continues to meet initial authorization criteria and has continued need for treatment **(assessed and documented by provider)**
- ❑ Reauthorization is being requested at least 30 months (Retisert®) or 36 months (Yutiq®) since previous implant (of the same eye)
- ❑ Member has experienced a response to treatment as indicated by an improvement in uveitis and lack of recurrence within the preceding 30 months (Retisert®) or 36 months (Yutiq®)
- ❑ No unacceptable complications/toxicities due to implant have occurred (e.g., pain, hyperemia, decreased visual acuity, conjunctival hemorrhage)
- ❑ Therapy was **NOT** discontinued for any of the following reasons:
  - ❑ Loss of visual acuity from baseline
  - ❑ Severely increased intraocular pressure
  - ❑ Limited benefit of treatment
  - ❑ Unacceptable toxicities/complications to implant (eye pain, hyperemia, conjunctival hemorrhage)
  - ❑ Contraindications/exclusions:
    - Hypersensitivity to fluocinolone or its components
    - Ocular or periocular infection
    - Advanced glaucoma
    - Concurrent intravitreal implant

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by Pharmacy and Therapeutics Committee:** 5/19/2022
REVISED/UPDATED: ~~5/7/2022; 8/7/2022,~~ **2/20/2025**