Outpatient Medical Injectable Intravitreal Injection Request Form
Fax to 833-581-1861
(Medical Benefit Only)

Member Name: _____

Member Date of Birth: _____

Member UMI: _____

Requesting Physician's Name: _____NPI Number: _____

Requesting Physician's Address: _____

Office Contact: _____ Phone Number: _____Fax Number: _____

Facility: _____Facility NPI Number: _____

Facility's Address: _____

Date of Service: _____

☐ EYLEA (J0178) ☐ BEOVU (J0179)

☐ LUCENTIS (J2778) ☐ MACUGEN (J2503)

☐ OTHER _____ (J_____)

ICD10:_____

Please check appropriate diagnosis and answer corresponding questions

☐ Neovascular (Wet) age-related macular degeneration (AMD)

Has the patient tried and failed Avastin? **YES / NO**

If yes, duration of treatment _____months

☐ Macular edema following retinal vein occlusion (RVO)

☐ Myopic Choroidal Neovascularization (mCNV) ***LUCENTIS ONLY***

☐ Diabetic retinopathy with or without diabetic macular edema

☐ Diabetic macular edema (DME)

☐ Other _____

☐ **OD** ☐ **OS** ☐ **OU**

☐ **New Start** ☐ **Continuation**

Date of last injection____/____/_____

AVASTIN (J9035, J3590) does NOT require authorization when prescribed by an ophthalmologist for intraocular use.

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-581-1861