HIGHMARK WESTERN NEW YORK

Outpatient Medical Injectable Intravitreal Injection Request Form
Fax to 833-619-5745
(Medical Benefit Only)

Member Name: _____

Member Date of Birth: _____

Member UMI: _____ ☐ Medicare ☐ Commercial

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: _____ ☐ ***Supplied by Alliance Rx Walgreens Specialty Pharmacy*** ☐ ***Buy & Bill*** ☐ ***Other_____***

☐ EYLEA (J0178)	☐ BEOVU (J0179)	☐ BYOOVIZ (Q5124)
☐ LUCENTIS (J2778)	☐ VABYSMO (J_____)	☐ MACUGEN (J2503)
☐ OTHER _____ (J_____)		☐ SUSVIMO (J2779)

ICD10:_____

Please check appropriate diagnosis and answer corresponding questions

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

- Has the member tried and failed Avastin? **YES / NO**
  If **YES, duration of treatment _____months
- **Susvimo only**: Has the member responded to at least 2 intravitreal injections of a VEGF inhibitor within the past 6 months? **YES / NO**

☐ 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____/____/_____**

*** Has the member experienced a positive clinical response to therapy? ☐ YES ☐ NO**

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 1-833-619-5745