



Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Avastin, Lucentis, Macugen
Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. Which drug is being prescribed? Avastin Lucentis Macugen Other _____
2. What is the diagnosis?
 Wet age-related macular degeneration (AMD)
 Macular edema due to retinal vein occlusion (RVO)
 Other _____
3. Does the patient have an ocular or periocular infection? Yes No
4. Will the prescribed agent be used as monotherapy? Yes No
5. Is the patient currently receiving the prescribed agent? Yes No

Only answer the below questions if patient is currently on therapy with the prescribed agent.

6. Has the patient been evaluated for choroidal neovascular leakage as detected on fluorescein angiography? Yes No
7. Has the patient experienced efficacy with prior treatment? Yes No
8. **Attach documentation to support prior treatment efficacy.**

****NOTE: We can NOT make a decision without a copy of the documentation - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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