peach state health plan

Voretigene neparvovec-rzyl (Luxturna)

Prior Authorization Form/Prescription

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information (*Attach copies of cards*)

*Primary Insurance:		Secondary Insurance:	
*ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

*Name:	*Specialty:	NPI:	
Address:	City:	State:	Zip:
*Phone #:	Secure Fax #:	Office Contact:	

Administrating Facility

*Facility Name:

Primary Diagnosis

*ICD-10 Code: _____

☐ Retinal dystrophy (Leber congenital amaurosis) ☐ Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Luxturna (voretigene neparvovec-rzyl)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

* **THERAPY TYPE (choose one):** ☐ INITIAL THERAPY ☐ CONTINUATION OF THERAPY - Therapy start date: _____

1. Has patient had a positive response to the prescribed therapy? ☐ Yes: _____ ☐ No ☐ Not applicable
2. Has patient previously been treated with Luxturna in the requested treatment eye(s)? ☐ Yes ☐ No
3. How many days have passed since treatment of first eye? _____ days

Complete this section ONLY if the patient is <u>initiating</u> therapy OR if the patient is <u>new</u> to this health plan:

4. Is therapy prescribed by or in consultation with an ophthalmologist? ☐ Yes ☐ No
5. Is diagnosis confirmed by presence of biallelic *RPE65* gene mutations? ☐ Yes ☐ No
6. Does patient have sufficient viable retinal cells evidenced by any of the following? ☐ Yes ***Mark all that apply*** ☐ No
   ☐ Retinal thickness on spectral domain optical coherence tomography (i.e., areas of retina with thickness measurements > 100 microns within the posterior pole)
   ☐ Fundus photography (i.e., presence of neural retina)
7. Does patient have significant vision loss evidenced by any of the following? ☐ Yes ***Mark all that apply*** ☐ No
   ☐ Visual acuity of 20/60 or worse in both eyes ☐ Visual field less than 20 degrees in any meridian
8. Has patient received intraocular surgery within the prior 6 months? ☐ Yes ☐ No
9. Please document patient's baseline full-field stimulus testing (FST) for blue and red light score: _____ log10(cd/m^2)

Complete this section ONLY for indications <u>other</u> than retinal dystrophy:

10. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐ Yes ☐ No
    If yes, submit documentation and answer the following:
    a. Please list all previous therapies: _____
    b. Was patient adherent to previously tried therapies? ☐ Yes ☐ No ☐ No, patient intolerant to drug

Please continue to page 2.

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Patient Name: _____ **DOB:** _____

Physician's Signature: _____ **Date:** _____ ☐ DAW

INFORMATION BELOW IS TO BE COMPLETE BY THE HEALTH PLAN/EPS PA STAFF

Authorization Information

***Authorization number:**	***Decision Due Date:**
***J-Code:**	***Coverage:** ❑ State excludes ❑ COB (secondary)
***Line of Business:** ❑ Commercial ❑ Health Insurance Marketplace ❑ Medicaid ❑ Medicare	***Benefit:** ❑ Medical ❑ Pharmacy

***Criteria:**

❑ Centene Policy

Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

❑ State Specific (please include policy)

❑ Medicare Local Coverage Decision (LCD) specific for your region (please include policy of link to LCD)

❑ Medicare National Coverage Decision (NCD) (please include policy of link to NCD)