

Voretigene neparvovec-rzyl (Luxturna) Prior Authorization Form/Prescription

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

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Date:	Date Medication Required:
Ship to: O Physician	n O Patient's Home O Other

*Last Name:	Patient Information							
Address: City: State: Zip:			*First Name:	Mic	ddle:	*DOB	: /	/
Daytime Phone:	Address:							Zip:
Secondary Insurance:	Daytime Phone:		Evening Phone	•	×	Sex:	Male	-
*TOP # Group # ID # I		Attach copies (-
*TOP # Group # ID # I		•		Secondary Insurance:				
Physician Information *Name:	*ID #	G	Group #	ID#			Group #	
*Name:	City:		State:	City:			State:	
### Address: City:	Physician Information							
*Phone #: Secure Fax #: Office Contact: Administrating Facility *Facility Name: Primary Diagnosis *ICD-10 Code: Retinal dystrophy (Leber congenital amaurosis) Other: Other	*Name:		* S	pecialty:			NPI:	
**Ifyes, submit described by or in consultation with an ophthalmologist?	Address:			City:			State:	Zip:
*Facility Name: Primary Diagnosis	*Phone #:		Secure Fax #:		Office Co	ntact:		
*ICD-10 Code: Retinal dystrophy (Leber congenital amaurosis) Other:	Administrating Facility							
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Retinal dystrophy (Leber congenital amaurosis) Other:	Primary Diagnosis							
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 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 initiating therapy OR if the patient is new 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 No Sepatient have significant vision loss evidenced by any of the following? No			ırosis)Other:					
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PDAC updated: 11/30/21



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Date:	Date Medication Required:		
Ship to: O Physicia	n O Patient's Home O Other		

Patient Name:	DOB:			
Physician's Signature:	Date: DAW			
INFORMATION BELOW IS TO BE COMPL	ETE 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)				

PDAC updated: 11/30/21