



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

Member Name: _____

Member Date of Birth: _____

Member ID (UMI): _____ [] Medicare [] Commercial

Ordering/Attending Provider Name: _____ NPI: _____

Ordering/Attending Provider Address: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

Servicing Facility/Vendor: _____ Facility NPI: _____

Servicing Facility/Vendor Address: _____ Requested Date of Service: _____

[] Buy & Bill [] Drug Supplied by Specialty Pharmacy (Pharmacy Name: _____ NPI: _____)

- [] EYLEA (J0178) [] CIMERLI (Q5128) [] BEOVU (J0179) [] SYFOVRE (J2781)
[] EYLEA HD (J0177) [] BYOOVIZ (Q5124) [] MACUGEN (J2503) [] IZERVAY (J2782)
[] LUCENTIS (J2778) [] VABYSMO (J2777) [] SUSVIMO (J2779) [] OTHER _____ (J_____)

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)
[] Geographic atrophy (GA) secondary to nonexudative (dry) AMD
[] 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

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