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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****