BlueCross BlueShield Federal Employee Program

RANIBIZUMAB
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Ranibizumab

NOTE: Form must be completed in its **entirety** for processing

Please select medication: ❑Byooviz (ranibizumab-nuna) ❑Cimerli (ranibizumab-eqrn) ❑Lucentis (ranibizumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?
   - ❑ Diabetic macular edema (DME)
   - ❑ Diabetic retinopathy (DR)
   - ❑ Macular edema following retinal vein occlusion (RVO)
   - ❑ Myopic choroidal neovascularization (mCNV)
   - ❑ Neovascular (wet) age-related macular degeneration (AMD)
   - ❑ Other ***(please specify):*** _____

2. Does the patient have either an ocular or periocular infection? ❑Yes ❑No

3. Will this medication be used in combination with other ***vascular endothelial growth factor (VEGF) inhibitors, other than Susvimo (ranibizumab)? ❑Yes* ❑No
   If YES, please specify the medication: _____

   VEGF Inhibitors: Avastin (bevacizumab), Beovu (brolucizumab-dbll), Eylea/Eylea HD (aflibercept), Lucentis (ranibizumab), Susvimo (ranibizumab), Vabysmo (faricimab-svoa)

4. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following question(s):
   a. Is there documentation of a baseline visual acuity test? ❑Yes ❑No
   b. **Lucentis Request**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Byooviz or Cimerli? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Has the patient demonstrated a positive clinical response to therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss)? ❑Yes ❑No