BlueCross BlueShield Federal Employee Program

OPHTHALMIC VEGF INHIBITORS 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					

Eylea / Eylea HD (aflibercept)

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

Please select medication: ❑**Eylea (aflibercept)** ❑**Eylea HD (aflibercept)**

****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. 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:

a. What is the patient's diagnosis?

❑Diabetic Macular Edema (DME) **OR** ❑Diabetic Retinopathy (DR)
i. Is there documentation of a baseline visual acuity test? ❑Yes ❑No

❑Macular edema following Retinal Vein Occlusion (RVO)
i. Is there documentation of a baseline visual acuity test? ❑Yes ❑No

❑Neovascular (wet) Age-related Macular Degeneration (AMD)
i. Is there documentation of a baseline visual acuity test? ❑Yes ❑No

❑Retinopathy of Prematurity (ROP)

❑None of the above

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Diabetic Macular Edema (DME) **OR** ❑Diabetic Retinopathy (DR)
i. 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

❑Macular edema following Retinal Vein Occlusion (RVO)
i. 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

❑Neovascular (wet) Age-related Macular Degeneration (AMD)
i. 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

❑Retinopathy of Prematurity (ROP)
i. Has the patient demonstrated a positive clinical response to therapy (e.g., no clinically significant reactivations of ROP)? ❑Yes ❑No

❑ None of the above

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

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

3. Does the patient have active intraocular inflammation? ❑Yes ❑No

4. Will this medication be used in combination with other ***vascular endothelial growth factor (VEGF) inhibitors for ocular indications? ❑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)