

BlueShield. OPHTHALMIC VEGF INHIBITORS Federal Employee Program. 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 Fay: 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

Patient Information (required)				Provider Information (required)		
Date:		-		Provider Name:		-
Patient Name:			Specialty:	NPI:	NPI:	
Date of Birth: Sex: □Male		□Female	Office Phone:	Office Fax	Office Fax:	
Street Address:				Office Street Address:		
City:		State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:			
N.]	PHYSICIAN	COMPLETES		_
	**Check v	www.fepblue.org/for	rmulary to confir	TEGF Inhibitors m which medication is part of the din its entirety for process.	_	
Is this request for	r brand or generic	? □Brand □C	Generic			
1. Please select	medication and a	answer the follow	wing questions	:		
□ Beovu (bro	olucizumab-dbll))				
,	the patient's diag					
	etic macular edem					
	ascular (wet) age-		legeneration (A	AMD)		
	of the above	1010000 1110001111	, egeneramon (r			
□ Vabysmo ((faricimab-svoa)					
-	the patient's diag	mosis?				
	etic macular edem					
☐Macular edema following retinal vein occlusion (RVO)						
□Neov	ascular (wet) age-	related macular d	degeneration (A	AMD)		
□None	of the above					
2. Does the patie	ent have either an	ocular or periocu	lar infection?	□Yes □No		
3. Does the patie	ent have active int	raocular inflamm	nation? □Yes	□No		
	ication be used in □Yes* □No	combination with	h other *vascul	ar endothelial growth fact	tor (VEGF) inhibitors	for ocular
* <i>If YES</i> , pl	ease specify the n	nedication:				
	Inhibitors: Avastin umab), Vabysmo (fa		eovu (brolucizun	nab-dbll), Eylea/Eylea HD (aflibercept), Lucentis (1	ranibizumab), Susvimo
5. Has the patier	nt been on this me	dication continuo	ously for the las	st 6 months , excluding san	mples? Please select ar	nswer below:
\square NO – this i	s INITIATION o	of therapy, please	answer the fol	lowing question:		
	e documentation of					
□ YES – this	is a PA renewal f	for CONTINUAT	TION of thera	by, please answer the follo	owing question:	
			_	e to therapy (e.g., improve		n 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)? \square Yes