Trillium Community Health Plan

Voretigene neparvovec-rzyl (Luxturna)

Prior Authorization Form/Prescription

PLEASE COMPLETE ALL SECTIONS FOR A TIMELY REVIEW

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other: _____

Patient Information

Last Name:	First Name:	Middle:	DOB: ____ /____ /_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male ☐ Female	

Insurance Information (*Attach copies of cards*)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone #:	Secure Fax #:	Office Contact:	

Primary Diagnosis

ICD-10 Code: _____

☐ Retinal dystrophy (Leber congenital amaurosis) ☐ Other: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Luxturna (voretigene neparvovec-rzyl)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY;** Therapy start date: _____

1. Has patient had a positive response to the prescribed therapy? ☐ Yes ☐ No ☐ Not applicable
2. Has patient previously been treated with Luxturna in the requested treatment eye(s)? ☐ Yes ☐ No
3. How many days have passed since treatment of first eye? _____ days

Complete this section ONLY if the patient is <u>initiating</u> therapy OR if the patient is <u>new</u> to this health plan:

4. Is therapy prescribed by or in consultation with an ophthalmologist? ☐ Yes ☐ No
5. Is diagnosis confirmed by presence of biallelic *RPE65* gene mutations? ☐ Yes ☐ No
6. Does patient have sufficient viable retinal cells evidenced by any of the following? ☐ Yes ***Mark all that apply*** ☐ No
   - ☐ Retinal thickness on spectral domain optical coherence tomography (i.e., areas of retina with thickness measurements > 100 microns within the posterior pole)
   - ☐ Fundus photography (i.e., presence of neural retina)
7. Does patient have significant vision loss evidenced by any of the following? ☐ Yes ***Mark all that apply*** ☐ No
   - ☐ Visual acuity of 20/60 or worse in both eyes
   - ☐ Visual field less than 20 degrees in any meridian
8. Has patient received intraocular surgery within the prior 6 months? ☐ Yes ☐ No
9. Please document patient's baseline Multi-Luminance Mobility Testing (MLMT) score: _____
10. Please document patient's baseline full-field stimulus testing (FST) for blue and red light score: _____ log10(cd/m^2)

Complete this section ONLY for indications <u>other</u> than retinal dystrophy:

11. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐ Yes ☐ No
    If yes, submit documentation and answer the following:
    a. Please list all previous therapies:
    _____
    b. Was patient adherent to previously tried therapies? ☐ Yes ☐ No ☐ No, patient intolerant to drug

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Ship to: ❍ Physician ❍ Patient's Home ❍ Other: _____

Physician's Signature: _____ **Date:** _____ ☐ DAW

INFORMATION BELOW IS TO BE COMPLETE BY THE HEALTH PLAN/EPS PA STAFF

Authorization Information

Authorization number:	**Decision Due Date:**
J-Code:	**Coverage:** ❑ State excludes ❑ COB (secondary)
Line of Business: ❑ Commercial ❑ Health Insurance Marketplace ❑ Medicaid ❑ Medicare	**Benefit:** ❑ Medical ❑ Pharmacy

Criteria:

❑ Centene Policy

Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____

❑ State Specific (please include policy)

Medicare only criteria for CY2019 and CY2020:

❑ PART B use LCD or NCD ❑ PART D use MCPD.PA.247 Tier and Formulary Exceptions Request Criteria