



BlueCross
BlueShield

Federal Employee Program

**RANIBIZUMAB
PRIOR APPROVAL REQUEST**

Send completed
form to:
FAX: 855-895-3504
FOR URGENT FAX:
844-244-0226

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: <input type="checkbox"/> Male <input type="checkbox"/> 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 diagnosis (*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-dbl), Eylea (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 questions:
 - a. Is there documentation of a baseline visual acuity test? Yes No
 - b. Does the patient have an intolerance, contraindication, or have they had an inadequate treatment response, or limited access to Avastin (bevacizumab)? 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

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Ranibizumab – FEP MD Fax Form Revised 11/18/2022