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: ❑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 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-dbll), 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