

Voretigene neparvovec-rzyl (Luxturna)

Prior Authorization Form/Prescription

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



Health Net Health Plan of Oregon, Inc.
 Health Net Life Insurance Company
Prior Authorization / Formulary Exception Request Fax Form
FAX TO: (800) 255-9198

Form must be fully completed to avoid a processing delay.

For status of a request, call: (888) 802-7001

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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: _____

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

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

- Is therapy prescribed by or in consultation with an ophthalmologist? Yes No
- Is diagnosis confirmed by presence of biallelic RPE65 gene mutations? Yes No
- 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)
- 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
- Has patient received intraocular surgery within the prior 6 months? Yes No
- Please document patient's baseline Multi-Luminance Mobility Testing (MLMT) score: _____
- Please document patient's baseline full-field stimulus testing (FST) for blue and red light score: _____ log10(cd/m²)

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Complete this section ONLY for indications other 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

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: <input type="checkbox"/> State excludes <input type="checkbox"/> COB (secondary)
Line of Business: <input type="checkbox"/> Commercial <input type="checkbox"/> Health Insurance Marketplace <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	Benefit: <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy
Criteria: <input type="checkbox"/> Centene Policy Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan): _____ <input type="checkbox"/> State Specific (please include policy)	
Medicare only criteria for CY2019 and CY2020: <input type="checkbox"/> PART B use LCD or NCD <input type="checkbox"/> PART D use MCPD.PA.247 Tier and Formulary Exceptions Request Criteria	