Luxturna

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: ______________________________ **Date**: ________________________________
Patient's ID: _____________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** ________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ____________________

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: __________________________*kg*

*Patient Height:*___________________________*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Luxturna SGM 2458-A – 06/2022.

Criteria Questions:

1. What is the diagnosis?
   ❑ Biallelic RPE65 mutation-associated retinal dystrophy
   ❑ Other ____

2. What is the ICD-10 code? ____________

3. Is there confirmation of bi-allelic pathogenic and/or likely pathogenic RPE65 gene mutations?
   ❑ Yes ❑ No

4. Please indicate which of the following genetic tests was performed to confirm bi-allelic pathogenic and/or likely pathogenic RPE65 gene mutations. ***ACTION REQUIRED: Attach genetic test results (single gene test or multi gene panel test) confirming a genetic diagnosis of pathogenic/likely pathogenic biallelic RPE65 gene mutations***.
   ❑ Single gene panel test
   ❑ Multi gene panel test
   ❑ None of the above

5. Are the RPE65 gene mutations classifications based on the current American College of Medical Genetics and Genomics (ACMG) standards and guidelines for the interpretation of sequence variants? ❑ Yes ❑ No

6. Please provide the date of the genetic test: ____________________

7. Has pathogenicity of the RPE65 mutations been affirmed within the last 12 months? ❑ Yes ❑ No

8. Which of the following test(s) was performed to confirm that the patient has viable retinal cells in each eye to be treated?
   ❑ Optical coherence tomography (OCT)
   ❑ Ophthalmoscopy
   ❑ Optical coherence tomography (OCT) and ophthalmoscopy
   ❑ None of the above

9. Does the patient have an area of the retina within the posterior pole of greater than 100 micrometer thickness shown on optical coherence tomography (OCT)? *If Yes, skip to #12* ❑ Yes ❑ No ❑ Unknown

10. Within the posterior pole, how many disc areas of the retina are without atrophy or pigmentary degeneration?
    ____________❑ Unknown *If three or more, skip to #12*

11. Is the patient's remaining visual field within 30 degrees of fixation as measured by a III4e isopter or equivalent?
    ❑ Yes ❑ No ❑ Unknown

12. Has the patient had the requested drug in the past?
    ❑ Yes ❑ No *If No, no further questions*

13. Please select the eye which was treated in the past: ❑ Right eye ❑ Left eye ❑ Both eyes

14. Is this request for a right eye or left eye treatment? ❑ Right eye ❑ Left eye

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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