UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Encelto (Revakinagene taroretcel)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met)

1. Is the patient 18 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of idiopathic macular telangiectasia type 2 (MacTel) with **BOTH** of the following criteria? ❑ **Yes** ❑ **No**
   - ☐ Inner segment/outer segment (IS/OS PR) break in ellipsoid zone (EZ) by spectral domain-optical coherence tomography (SD-OCT)
   - ☐ Best corrected visual acuity (BCVA) of 54 letter score or better as measured by the Early Treatment Diabetic Retinopathy Study (ETDRS) chart or equivalent to Snellen eye chart visual acuity of 20/80
3. Is the implant being prescribed and administered by an ophthalmologist specializing in the care of patients with macular telangiectasia? ❑ **Yes** ❑ **No**
4. Is this the first eye the patient will be receiving Encelto Implant, **OR** has the patient received Encelto in a different eye and has the first eye demonstrated clinical benefit? ❑ **Yes** ❑ **No**
   a. If second eye, details of first eye: ____
5. Does the provider attest that the patient does **NOT** have any of the following:? ❑ **Yes** ❑ **No**
   - ☐ Active or suspected ocular or periocular infections
   - ☐ Hypersentivity to Endothelial Serum Free Media (Endo-SFM)
   - ☐ Neovascular MacTel

6. Does the provider attest to complete all post-implant monitoring and counseling described in the current Encelto prescribing information, including the following:? ❑ **Yes** ❑ **No**
   - ☐ Associated side effects
   - ☐ Advising the patient to seek immediate care from an ophthalmologist if they experience any signs or symptoms of:
     - i. An increase in floaters, the appearance of “spider webs”, flashing lights, sensitivity to light, or loss of vision or visual field
     - ii. Increasing eye pain, progressive redness in the white of the eye, a sudden sensation that something is in their eye (i.e., foreign body sensation) or eye discharge
   - ☐ Evaluate implant positioning after 6 months, then annually

Initial Authorization: One (1) implant per eye per lifetime
Reauthorization: None

Note:

- ❖ Use appropriate HCPCS code for billing:
  Coverage and Reimbursement code lookup: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_______________________________ _______________

Prescriber’s Signature Date

For ADA accommodation or assistance completing this form, please call us at 801-538-6155.