UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Ophthalmic Corticosteroid Intravitreal Implants/Injections

(Iluvien, Ozurdex, Retisert, Triesence, Xipere, Yutiq)

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 at least 18 years of age or older (12 years of age of Retisert)? ❑ **Yes** ❑ **No**
2. Is the implant or injection being prescribed and administered by an ophthalmologist? ❑ **Yes** ❑ **No**

Iluvien Additional Criteria:

3. Does the patient have a diagnosis of Diabetic Macular Edema (DME)? ❑ **Yes** ❑ **No**
4. Has the patient been previously treated with a course of ophthalmic corticosteroids, without a clinically significant rise in intraocular pressure? ❑ **Yes** ❑ **No**
   Medication and Dose: _____ Duration of Use: _____
5. Has the patient previously undergone at least one prior macular laser photocoagulation treatment? ❑ **Yes** ❑ **No**
6. Has the patient had a failure or suboptimal response to anti-VEGF treatment after 24 weeks? ❑ **Yes** ❑ **No**

Ozurdex Additional Criteria:

7. Does the patient have a diagnosis of one of the following conditions? ❑ **Yes** ❑ **No**
   - ☐ Diabetic Macular Edema (DME)
   - ☐ Macular Edema following branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO)
   - ☐ Non-Infectious Uveitis affecting the posterior segment of the eye
8. For a diagnosis of Macular edema with BRVO or CRVO, has the patient had a failure or

suboptimal response to anti-VEGF treatment after 24 weeks? ❑ **Yes** ❑ **No**
Duration of Use: _____ Details of Failure: _____

Retisert Additional Criteria:

9. Does the patient have a diagnosis of chronic (one year or greater) non-infectious uveitis affecting the posterior segment of the eye? ❑ **Yes** ❑ **No**
10. Has the patient tried and failed or had an intolerance to Humira (adalimumab) for at least 6 weeks within the last year? ❑ **Yes** ❑ **No**
    Duration of Use: _____ Details of Failure: _____

Triesence Additional Criteria:

11. Does the patient have a diagnosis of one of the following conditions? ❑ **Yes** ❑ **No**
    - ☐ Visualization during vitrectomy
    - ☐ Sympathetic ophthalmia
    - ☐ Temporal arteritis
    - ☐ Uveitis
    - ☐ Ocular inflammatory conditions unresponsive to ophthalmic corticosteroids
12. For a diagnosis of Ocular inflammatory conditions unresponsive to ophthalmic corticosteroids, has the patient tried and failed an ophthalmic corticosteroid? ❑ **Yes** ❑ **No**
    Medication and Dose: _____ Duration of Use: _____
    Details of Failure: _____

Xipere Additional Criteria:

13. Is the medication being used for the treatment of macular edema associated with uveitis? ❑ **Yes** ❑ **No**
14. Has the patient tried and failed or had an intolerance to Humira (adalimumab) for at least 6 weeks within the last year? ❑ **Yes** ❑ **No**
    Duration of Use: _____ Details of Failure: _____

Yutiq Additional Criteria: (*All* of the following criteria must be met)

15. Does the patient have a diagnosis of Chronic Non-Infectious Uveitis affecting the posterior segment of the eye? ❑ **Yes** ❑ **No**
16. Has the patient tried and failed or had an intolerance to Humira (adalimumab) for at least 6 weeks within the last year? ❑ **Yes** ❑ **No**
    Duration of Use: _____ Details of Failure: _____

Reauthorization Criteria:

1. Has the patient had clinically significant improvement as shown by the specific appropriate monitoring parameters and/or improvement in symptoms? Chart note page #: _____ ❑ **Yes** ❑ **No**

Initial Authorization: Up to 6 months
Reauthorization: Up to 1 year

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

_____ _____
Prescriber's Signature Date