

**Anthem UM
Services, Inc.**

**Treatment for Age Related Macular Degeneration
PreDetermination of Medical Benefits
[Macugen® (pegaptanib) & Lucentis® (ranibizumab)]
Complete form in its entirety and fax to UM Call Center at (404) 848-2448**

Click on grey boxes to type		Request Date:	/	/
<input type="checkbox"/> Initial Authorization Request	<input type="checkbox"/> Subsequent Request; List Prior Auth Ref #:			
<input type="checkbox"/> Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800.870.6419)				

1. PATIENT INFORMATION

Patient Last Name	Patient First Name	Anthem Member ID Number	Patient DOB / /
Contact Phone Number () -	Primary Diagnosis	ICD-9 Code(s)	Patient's Weight (lbs) Date: _____

2. PHYSICIAN INFORMATION

Physician Last Name	Physician First Name	Physician DEA or NPI Number	Physician Tax ID
Address		City	State Zip Code
Office Phone Number () -	Office Fax Number () -	Office Contact Name	Physician Specialty

3. MEDICATION INFORMATION – This section serves as the active prescription – signature required.

Drug Name <input type="checkbox"/> Macugen <input type="checkbox"/> Lucentis	HCPCS or CPT Code(s) <input type="checkbox"/> J2503 <input type="checkbox"/> J2778	Strength / Dose
Direction for Use (SIG)		
Date patient is scheduled to be treated (need by date) / /	Service From Date / /	Service Thru Date / /
Number of Refills		
Ship Medication to: <input type="checkbox"/> MD Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other: (please specify)		

4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: To avoid delays, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended.
If indicated, please provide ALL supporting lab results, progress notes, etc

(1) Age Related Macular Degeneration (AMD)

Yes No Is patient diagnosed with neovascular "wet" AMD?

Yes No Does patient currently present with any ocular or periocular infections?

(2) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

5. PHYSICIAN SIGNATURE

Prescriber's or Authorized Representative's Signature: _____	Date: ____/____/____
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Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is **STRICTLY PROHIBITED**. If you have received this message by error, please notify us immediately at 800-722-6614 and destroy the related message or return the document to us at 3350 Peachtree Rd. NE, Atlanta, GA 30326. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.

Medical Policy Reference can be found at: www.bcbsga.com

Anthem UM Services, Inc. an independent company and is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.