



# MEDICARE FORM

## VABYSMO™ (faricimab-svoa) Injectable Medication Precertification Request

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(All fields must be completed and legible for precertification review.)

Virginia (HMO D-SNP)  
FAX: 1-833-280-5224  
PHONE: 1-855-463-0933

For other lines of business:  
Please use other form.

**Note: Vabysmo is non-preferred. The preferred product is bevacizumab (Avastin). Avastin (C9257), Alymsys, Mvasi, and Zirabev do not require precertification for ophthalmic use.**

Please indicate:  Start of treatment, start date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Continuation of therapy, date of last treatment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Precertification Requested By: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone: E-mail:	
Current Weight: ____ lbs or ____ kgs			Height: ____ inches or ____ cms		Allergies:

### B. INSURANCE INFORMATION

Member ID #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:

### C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.			
Address:			City:		State:		ZIP:
Phone:		Fax:		St Lic #:		NPI #: DEA #: UPIN:	
Provider E-mail:			Office Contact Name:			Phone:	
Specialty (Check one): <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Other: _____							

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ NPI: _____	<b>Dispensing Provider/Pharmacy: (Patient selected choice)</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ FAX: _____ TIN: _____ PIN: _____ NPI: _____
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### E. PRODUCT INFORMATION

Request is for:  VABYSMO (faricimab-svoa)  
Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ HCPCS code: \_\_\_\_\_

### F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (\*).

Primary ICD Code: \_\_\_\_\_  Other ICD Code: \_\_\_\_\_

### G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

**For Initiation Requests (clinical documentation required for all requests):**  
**Note: Vabysmo is non-preferred. The preferred product is bevacizumab (Avastin). Avastin (C9257), Alymsys, Mvasi, and Zirabev do not require precertification for ophthalmic use.**

Yes  No Has the patient had prior therapy with Vabysmo (faricimab-svoa) within the last 365 days?  
 Yes  No Has the patient had a trial, intolerance, or contraindication to bevacizumab (Avastin)?  
Please explain if there are any other medical reason(s) that the patient cannot use bevacizumab (Avastin)

#### Please select the diagnosis:

- Diabetic macular edema
- Neovascular (wet) age-related macular degeneration (AMD)

Continued on next page



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.**

**For Continuation Requests (clinical documentation required for all requests):**

Yes  No Has the patient demonstrated a positive clinical response to therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss)?

**H. ACKNOWLEDGEMENT**

**Request Completed By (Signature Required):** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.