



MEDICARE FORM

Beovu® (brolucizumab-dbl) Injectable Medication Precertification Request

Page 1 of 2

(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: Beovu is non-preferred.

The preferred products are Avastin, Mvasi, and Zirabev. Avastin (C9257), 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:			
Address:			City:	State:	ZIP:
Home Phone:		Work Phone:		Cell Phone:	
DOB:	Allergies:			E-mail:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms			

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

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

E. PRODUCT INFORMATION

Request is for Beovu (brolucizumab-dbl) Dose: _____ Directions for Use: _____

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 All Requests: (clinical documentation required for all requests)

Note: Beovu is non-preferred. The preferred products are Avastin, Mvasi and Zirabev. Avastin (C9257), Mvasi, and Zirabev do not require precertification for ophthalmic use.

Yes No Has the patient had prior therapy with Beovu (brolucizumab-dbl) within the last 365 days?

Yes No Has the patient had a trial, intolerance, or contraindication to Avastin, Mvasi, or Zirabev?

Please explain if there are any other medical reason(s) that the patient cannot use Avastin, Mvasi, or Zirabev.

For Initiation Requests (clinical documentation required for all requests):

Please select the diagnosis:

Neovascular (wet) age related macular degeneration

Other: _____

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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.