



Visudyne

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ *kg*
Patient Height: _____ *cm*

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

What is the ICD-10 code? _____

Clinical Criteria Questions:

1. What is the diagnosis?
 Predominantly classic subfoveal choroidal neovascularization (*If checked, go to 2*)
 Choroidal hemangioma (*If checked, go to 3*)
 Other, please specify. _____ (*If checked, no further questions*)
2. Is the patient currently receiving treatment with the requested medication?
 Yes, *Continue to 6*
 No, *Continue to 4*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Visudyne SGM 3011-A – 08/2023.

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3. Is the patient currently receiving treatment with the requested medication?

Yes, *Continue to 6*

No, *No Further Questions*

4. Does the patient have predominantly classic subfoveal choroidal neovascularization (CNV) due to one of the following?

Yes, age-related macular degeneration (*If checked, go to 5*)

Yes, pathologic myopia (*If checked, go to 5*)

Yes, presumed ocular histoplasmosis (*If checked, go to 5*)

Yes, chronic central serous chorioretinopathy (also includes retinal pigment epithelial leakage without evident CNV) (*If checked, go to 5*)

No (*If checked, go to 5*)

5. Is the treatment spot size less than or equal to 6.4 mm in diameter?

Yes, *No Further Questions*

No, *No Further Questions*

6. Has the patient demonstrated a positive clinical response to the requested drug therapy?

Yes, *No Further Questions*

No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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