ATRIO HEALTH PLANS

Geographic Atrophy
Syfovre (pegcetacoplan) J2781
Izervay (avacincaptad pegol)) J2782
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ **Syfovre J2781** ☐ **Izervay J2782**

☐ **New Start or Initial Request: (Clinical documentation required for all requests)**

- ☐ Diagnosis of geographic atrophy of the macula secondary to age-related macular degeneration (AMD)
- ☐ Diagnosis has been verified by geographic atrophy sensitive tests (including but not limited to optical coherence tomography, fluorescein angiography, fundus photography).
- ☐ Diagnosis confirmed by fundus autofluorescence (FAF) imaging showing **ALL** of the following:
  - a) Total GA area must be ≥ 2.5 and ≤ 17.5 mm2 (1 and 7 disk areas [DA] respectively) and
  - b) If GA is multifocal, at least one focal lesion must be ≥ 1.25 mm2 (0.5 DA)
  - c) The GA lesion must be, in part, within 1.5 mm from, but NOT involving the foveal center; **AND**
- ☐ Documented best corrected visual acuity (BCVA) between 20/25 and 20/320 in affected eye(s); **AND**
- ☐ Member does NOT have any of the following:
  - d) GA secondary to any condition other than AMD
  - e) History or current evidence of wet AMD
- ☐ **Dosage/Quantity limit: Intravitreal inj to each affected eye once monthly: `2 vials per 28 days**

- Requests for may **NOT** be approved for the following:
  - Geographic atrophy that is secondary to a condition other than age-related macular degeneration (including but not limited to Stargardt disease, cone rod dystrophy or toxic maculopathies); OR
  - Patient has a history of or active choroidal neovascularization or wet age-related macular degeneration; OR,
  - Individual has an ocular or periocular infection(s); OR,
  - Individual has active intraocular inflammation;

☐ **Continuation Requests: (Clinical documentation required for all requests)**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request 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.

THIS AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Complement Inhibitor PA

Drug Name(s):

SYFOVRE	**PEGCETACOPLAN**
IZERVAY	**AVACINCAPTAD PEGOL**

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
   - If the member meets all these criteria, they may be approved by the Plan for the requested drug.
   - Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

- N/A

Prescriber Restrictions:

- N/A

Coverage Duration:

Approval will be for 6 months

FDA Indications:

Syfovre

- Geographic Atrophy (GA) secondary to Nonexudative age-related macular degeneration
- Paroxysmal nocturnal hemoglobinuria

Izervay

- Geographic Atrophy (GA) secondary to Nonexudative age-related macular degeneration

Off-Label Uses:

Syfovre

- N/A

Age Restrictions:

- Safety and effectiveness have not been established in pediatric patients

Other Clinical Consideration:

- N/A

Resouces:

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