HIGHMARK HEALTH OPTIONS

Updated: 04/2025
Approved: 04/2025

Request for Prior Authorization for Vascular Endothelial Growth Factor Inhibitors (VEGF) and Visudyne (verteporfin)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Vascular Endothelial Growth Factor Inhibitors (VEGF) and Visudyne (verteporfin) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below. ***This policy does not apply to oncology related requests.***

Vascular Endothelial Growth Factor Inhibitors (VEGF) and Visudyne (verteporfin)Prior Authorization Criteria:

For all requests for Vascular Endothelial Growth Factor Inhibitors (VEGF) and Visudyne (verteporfin), the following criteria must be met:

- The requested medication is being prescribed for a diagnosis that is indicated in the FDA- approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- The treatment is prescribed by, or in consultation with, an ophthalmologist or retinal specialist
- **Initial Duration of Approval:** 12 months

Reauthorization criteria

- Chart documentation demonstrating clinical benefit and tolerance to therapy

Reauthorization Duration of Approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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VASCULAR ENDOTHELIAL GROWTH FACTOR INHIBITORS (VEGF) AND VISUDYNE (VERTEPROFIN) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE: _____
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced an improvement with treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date