



Ophthalmic Implants

Dextenza (dexamethasone, lacrimal ophth insert) J1096, Retisert (fluocinolone acetonide implant) J7311, Ozurdex (dexamethasone implant) J7312, Iluvien (fluocinolone acetonide) J7313, Yutiq (fluocinolone acetonide) J7314, Durysta (bimatoprost) J7351, iDose TR (travoprost) J7355,
**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

☐ Dextenza J1096 ☐ Retisert J7311 ☐ Ozurdex J7312
☐ Iluvien J7313 ☐ Yutiq J7314
☐ Durysta J7351 ☐ iDose Tr J7355

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

- ☐ Prescribed by ophthalmologist or retinal specialist
☐ Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.

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

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

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 – Ophthalmic Implants PA

Drug Name(s):

RETISERT	FLUOCINOLONE ACETONIDE IMPLANT
OZURDEX	DEXAMETHASONE IMPLANT
DEXTENZA	DEXAMETHASONE LACRIMAL OPHTH INSERT
ILUVIEN	FLUOCINOLONE ACETONIDE INTRAVITREAL IMPLANT
YUTIQ	FLUOCINOLONE ACETONIDE INTRAVITREAL IMPLANT
DURYSTA	BIMATOPROST INTRACAMERAL IMPLANT
IDOSE TR	TRAVOPROST INTRACAMERAL IMPLANT

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Treatment 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:

- Ophthalmologist or Retinal Specialist

Coverage Duration:

Approval will be for 12 months

FDA Indications:

Retisert, Iluven,

- Macular edema due to diabetes mellitus
- Uveitis (Chronic), Non-infectious, posterior segment

Ozurdex, Dextenza

- Inflammatory disorder of the eye, Postoperative
- Macular edema due to diabetes mellitus
- Macular retinal edema
- Posterior uveitis, Noninfectious

Yutiq

- Non-infectious posterior uveitis (Chronic)

Durysta

- Ocular hypertension - Raised intraocular pressure
- Open-angle glaucoma - Raised intraocular pressure

iDose TR

- Raised intraocular pressure, In patients with open-angle glaucoma or ocular hypertension

Off-Label Uses:

- N/A

Age Restrictions:

- Safety and effectiveness have not been established in pediatric patients 12 years or younger.

Other Clinical Consideration:

- N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/938821/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/4D935D/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=235810&contentSetId=100&title=Fluocinolone+Acetonide&servicesTitle=Fluocinolone+Acetonide&brandName=Retisert&UserMdxSearchTerm=Retisert&=null#

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