



MEDICARE FORM

VABYSMO™ (faricimab-svoa) Injectable Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for precertification review.)

For Illinois MMP:

FAX: 1-855-320-8445

PHONE: 1-866-600-2139 (TTY: 711)

For other lines of business: Please use other form.

Note: Vabysmo is non-preferred. The preferred products are bevacizumab (Avastin) first followed by Byooviz. Avastin (C9257) and bevacizumab biosimilars 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

Form section A: Patient Information. Fields include First Name, Last Name, DOB, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, E-mail, Current Weight, Height, and Allergies.

B. INSURANCE INFORMATION

Form section B: Insurance Information. Fields include Member ID #, Group #, Insured, Medicare status, Medicaid status, and other coverage details.

C. PRESCRIBER INFORMATION

Form section C: Prescriber Information. Fields include First Name, Last Name, Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Office Contact Name, and Specialty.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Pharmacy Information. Divided into Place of Administration and Dispensing Provider/Pharmacy details.

E. PRODUCT INFORMATION

Form section E: Product Information. Fields include Request is for (VABYSMO), Dose, Frequency, and HCPCS code.

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

Form section F: Diagnosis Information. Fields include Primary ICD Code and Other ICD Code.

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

Form section G: Clinical Information. Includes initiation request requirements, a note about preferred products, and questions regarding patient history and medical reasons for not using bevacizumab or Byooviz.

Continued on next page



MEDICARE FORM

VABYSMO™ (faricimab-svoa) Injectable Medication Precertification Request

Page 2 of 2

(All fields must be completed and legible for precertification review.)

For Illinois MMP:

FAX: [1-855-320-8445](tel:1-855-320-8445)

PHONE: [1-866-600-2139](tel:1-866-600-2139) (TTY: 711)

For other lines of business:
Please use other form.

Note: Vabysmo is non-preferred.
The preferred products are bevacizumab (Avastin) first followed by Byooviz. Avastin (C9257) and bevacizumab biosimilars do not require precertification for ophthalmic use.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
--------------------	-------------------	---------------	-------------

G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Please select the diagnosis:

- Diabetic macular edema
- Neovascular (wet) age-related macular degeneration (AMD)

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.