EXPRESS SCRIPTS®

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Prior Authorization Request

LUCENTIS, BYOOVIZ, RANOPTO (ranibizumab)

Instructions

Please complete Part A and have your physician complete Part B. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. Please note that you have the right to appeal the decision made by Express Scripts Canada.

Part A – Patient

Patient information

First Name:	Last Name:	
Insurance Carrier Name/Number:		
Group Number:	Client ID:	
Date of Birth (YYYY/MM/DD):	Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French	Gender: ☐ Male ☐ Female	
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Coordination of benefits

Patient Assistance Program	Is the patient enrolled in any patient assistance program? ☐ Yes ☐ No Contact Name: _____ Fax: _____
Provincial Coverage	Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****

Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

_____ _____

Plan Member Signature Date

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

☐ LUCENTIS ☐ BYOOVIZ ☐ RANOPTO			☐ New request ☐ Renewal request*
Dose	Administration (ex: oral, IV, etc)	Frequency	Duration

Site of drug administration:

☐ Home ☐ Physician's office/Infusion clinic ☐ Hospital (outpatient) ☐ Hospital (inpatient)

* Please submit proof of prior coverage if available

SECTION 2 – ELIGIBILITY CRITERIA

1. **Please indicate if the patient satisfies the below criteria:**

Neovascular (Wet) Age-Related Macular Degeneration

☐ For the treatment of neovascular (wet) age-related macular degeneration (nAMD) in an adult

Diabetic Macular Edema

☐ For the treatment of diabetic macular edema (DME) in an adult

Macular Edema Secondary to Retinal Vein Occlusion

☐ For the treatment of visual impairment due to macular edema secondary to retinal vein occlusion (RVO) in an adult

Choroidal Neovascularization

☐ For the treatment of visual impairment due to choroidal neovascularization (CNV) secondary to pathologic myopia (PM) in an adult, OR

☐ For the treatment of visual impairment due to CNV secondary to ocular conditions other than neovascular age-related macular degeneration (nAMD) or PM in an adult

Retinopathy of Prematurity

☐ For the treatment of retinopathy of prematurity (ROP) in a preterm infant, AND

☐ The patient has bilateral ROP with zone I or zone II or aggressive posterior ROP (AP-ROP) disease

OR

☐ None of the above criteria applies.

Relevant additional information:

2. **Please list previously tried therapies**

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/ Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

3. **Additional criteria for LUCENTIS requests**

☐ The patient is intolerant to, or had a confirmed adverse event with a biosimilar *(Please indicate in the chart above)*

SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	Date:

Please fax or mail the completed form to Express Scripts Canada®

Fax: Express Scripts Canada Clinical Services
1 (855) 712-6329

Mail: Express Scripts Canada Clinical Services
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Mississauga, ON L5R 3G5