

Encelto™ (revakinagene taroretcel-lwey) Prior Authorization Form

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

Physician billing (HCPCS code: _____ **)** **Pharmacy billing (NDC:** _____ **)**
Start Date: _____

Billing Provider Information

Provider NPI: _____ **Provider Name:** _____
Provider Phone: _____ **Provider Fax:** _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____
Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Criteria

For Authorization: (a limit of 1 implant per eye per lifetime will apply)

1. Clinical documentation (i.e., recent office notes) must be submitted with the request documenting the member's treatment plan. Is this information attached? Yes ___ No ___

2. Please indicate the diagnosis and information

Idiopathic Macular Telangiectasia (MacTel)

- a. Is diagnosis idiopathic MacTel type 2? Yes ___ No ___
- b. Does the member have evidence of the following features typical of MacTel Type 2:
 - i. Fluorescein leakage? Yes ___ No ___
 - ii. Hyperpigmentation that is outside of a 500-micron radius from the center of the fovea? Yes ___ No ___
 - iii. Retinal opacification? Yes ___ No ___
 - iv. Crystalline deposits? Yes ___ No ___
 - v. Right-angle vessels? Yes ___ No ___
 - vi. Inner/outer lamellar cavities? Yes ___ No ___
- c. Is Encelto™ prescribed by and will it be administered by a qualified ophthalmologist under aseptic conditions? Yes ___ No ___
- d. Does member have a photoreceptor inner segment/outer segment (IS/OS PR) break (loss) in ellipsoid zone (EZ) between 0.16 and 2.00mm² measured by spectral domain-optical coherence tomography (SD-OCT)? Yes ___ No ___
- e. Does member have a best corrected visual acuity (BCVA) of 20/80 or better? Yes ___ No ___
- f. Does member have neovascular MacTel type 2? Yes ___ No ___
- g. Does member have ocular or periocular infections? Yes ___ No ___
- h. Does member have known hypersensitivity to Endothelial Serum Free Media (Endo-SFM)? Yes ___ No ___

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<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p><u>CONFIDENTIALITY NOTICE</u></p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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Encelto™ (revakinagene taroretcel-lwey) Prior Authorization Form**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Criteria****For Authorization:** *(a limit of 1 implant per eye per lifetime will apply)*2. Please indicate the diagnosis and information: *(continued)*

- i. Is the member taking an antithrombotic medication (i.e., oral anticoagulants, aspirin, and nonsteroidal anti-inflammatory drugs)? Yes ___ No ___
 - i. If yes, has member been counseled to temporarily discontinue therapy with their antithrombotic medication prior to Encelto™ implantation due to the risk of vitreous hemorrhage?
Yes ___ No ___
- j. Will the member be monitored for vision loss, infectious endophthalmitis, retinal tear and/or detachment, vitreous hemorrhage, implant extrusion, cataract formation, suture related complications, and delayed dark adaptation after Encelto™ implantation and treated, if appropriate? Yes ___ No ___
- k. Will both eyes be treated? Yes ___ No ___
- l. Please provide the date(s) of the scheduled procedure(s), if applicable:
 - i. Right eye: _____
 - ii. Left eye: _____

 Other: _____**Additional Information:** _____

_____**(Page 2 of 2)****Prescriber Signature:** _____ **Date:** _____***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.*****PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization UnitFax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE***This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*