Lucentis® (ranibizumab)
Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP 2

Diagnosis	☐ Neovascular (wet) Age Related Macular Degeneration ☐ Patient is refractory to other therapies: Avastin, Macugen, Visudyne,	☐ Other Diagnosis (please state):
Clinical Consideration	☐ Intravitreal injection(s) of Lucentis will be administered by an Ophthalmologist. ☐ Other practitioner (please state): ☐ **This patient has been informed of the potentially dramatic cost savings with the use of compounded Avastin (bevacizumab) and you have weighed the risks/benefits of using compounded Avastin for the treatment of AMD in place of Lucentis.**	
Physician Specialty	Diagnosis made by: ☐ Ophthalmologist ☐ Other (please state):	
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Lucentis® (ranibizumab) Strength _____ Sig _____ Qty _____ Refills _____	
	Please attach all relevant medical records and test results. **Incomplete forms will not be processed.**	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

_____ _____
Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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