

*Prescriber Signature: ____

Specialty Medication Review Program

Vabysmo[®] (faricimab-svoa) (Health Professional Administered) Medical Benefit

Complete this form and fax to:	If you are	not buying and billing	this medica	ation, indicate	which specialty	pharma	acy will be used:	
Fax #: 1-800-306-0188 F		☐ Noble Fax: 1-888-842-3977 Phone: 1-888-843-2040		☐ Accredo Health Fax: 1-888-773-7386 Phone: 1-866-413-4137		☐ Walgreens Specialty Pharmacy Fax: 1-866-435-2173 Phone: 1-866-435-2171		
Complete all the following Patie	ent/Prescribe	er information: (Please	Print)					
		Patien	t Informati					
Patient Name:				Patient Phone #: ()				
Patient ID #:				Patient Birthdate:				
List Patient Allergy (if any):								
Prescriber Information								
Prescriber Name:				Prescriber Specialty:				
Prescriber Address:								
Prescriber Phone #:				Prescriber Fax #:				
Prescriber NPI #:				Office Contact: Extension:				
Location of Infusion:								
☐ Prescriber office		☐ Home/Homecare						
☐ Outpatient facility		☐ Other:		_				
Servicing Prescriber NPI (if dif	ferent from th	ne ordering prescriber):						
Provide address of infusion lo	cation above	e for medication shipp	ing:					
		Medication/Medical	and Dispen	sing Informat	tion			
Medication (HCPCS)	Dose	Frequency		Height	Weight (lbs	s./kg)	Procedure Code	
Vabysmo (J2777)								
Diagnosis/ICD-10:								
Is this request for a: New	Start OR	☐ Continuation of The	nerapy (rec	ertification)?				
		Questions/Indication	ons for Me	dical Necessi	ty			
** See the Clinical	Review Prio	r Authorization Medica	al Policy (P	harmacy-63)	for full Prior A	uthoriza	ation criteria **	
Select one of the following dia	gnoses:							
☐ Neovascular (Wet) Age-	Related Mac	ular Degeneration (nAM	ID)					
☐ Macular Edema Followir	ng Retinal Ve	in Occlusion (RVO)						
□ Diabetic Macular Edema	a (DME)							
☐ Other:								
1. Is the prescriber an ophthalmologist?							☐ Yes ☐ No	
2. Has this patient had an adequate trial (define as at least 3 injections) of Eylea (aflibercept)?							☐ Yes ☐ No	
3. Has this patient had an adequate trial (define as at least 3 injections) of a ranibizumab-containing product?							☐ Yes ☐ No	
4. Has this patient had an adequate trial (define as at least 3 injections) of a bevacizumab-containing product?							☐ Yes ☐ No	
Provide any other commen	<u> </u>				<u> </u>		L	
		,						
*ATTACH CLINICAL NOTE	S RELATED T	O THIS REQUEST. IF DO	CUMENTAT	ION IS NOT PR	OVIDED, IT MAY	/ DELAY	THE REQUEST.	

I certify the above is true and accurate to the best of my knowledge.