ambetter. FROM peach state health plan

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Revakinagene Taroretcel-lwey (Encelto)
PDAC Drug Review Form

The information below can be completed by the Health Plan and/or Centene Pharmacy Services (CPS) staff

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: / /
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information

*Primary Insurance (Health Plan Name and State)	*ID #:

Physician Information

*Name:	*Specialty:	*Phone #:

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐ Macular telangiectasia type 2 (MacTel type 2) ☐ Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Encelto (Revakinagene Taroretcel-lwey)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

* **THERAPY Start Date**: _____

1. Is therapy prescribed by or in consultation with a retina specialist? ☐ Yes ☐ No
2. Is MacTel type 2 confirmed by one of the following? ☐ Yes ***Mark all that apply*** ☐ No
   ☐ Crystalline deposits ☐ Inner/outer lamellar cavities ☐ Retinal opacification ☐ Right angle vessels
   ☐ Fluorescein angiographic leakage of the retinal vessels ☐ Hyperpigmentation not involving the foveal center
3. Is ellipsoid zone (EZ) disruption between 0.16 mm² and 2.00 mm² as measured by optical coherence tomography (OCT)?
   ☐ Yes: _____ mm² ☐ No
4. Is best corrective visual acuity (BCVA) 54 letters or better on Early Treatment Diabetic Retinopathy Study (ETDRS) charts
5. (approximately 20/80 Snellen equivalent)? ☐ Yes: _____ letters ☐ No
6. Does patient have intraretinal or subretinal neovascularization? ☐ Yes ☐ No
7. Has the patient previously received an ocular implant containing Encelto in the affected eye(s)? ☐ Yes ☐ No
8. Which eye(s) is this request for? ☐ Right ☐ Left ☐ Both
9. How many ocular implants has patient previously received? ☐ Right eye: _____ ☐ Left eye: _____

Complete this section ONLY for indications <u>other</u> than MacTel type 2:

10. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐ Yes ☐ No
    If yes, submit documentation and answer the following:
    a. Please list all previous therapies: _____
    b. Was patient adherent to previously tried therapies? ☐ Yes ☐ No ☐ No, patient intolerant to drug

Information

*Number:	*Date of Request:
*HCPCS Code:	*Decision Due Date:
* Line of Business: ☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	* Benefit: ☐ Medical ☐ Pharmacy

PDAC updated: 09/08/2025
AMB25-GA-HP-00216

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*** Choose one criteria option below based on line of business:**

Medicare Criteria Only:

☐ Medicare Local Coverage Decision (LCD) specific for your region
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

Please continue to page 2.

Patient Name: _____ **DOB:** _____

☐ Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

Medicaid, Commercial, Exchange (Ambetter) Criteria:

☐ Centene Policy [**CP.PHAR.697 Revakinagene Taroretcel-lwey (Encelto)**]

Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan):

_____

OR

☐ State or Health Plan Specific (please include policy)