ambetter. FROM peach state health plan

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

Voretigene neparvovec-rzyl (Luxturna)
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 #:

Administrating Facility

*Facility Name:

Primary Diagnosis

*ICD-10 Code: _____
☐Retinal dystrophy ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Luxturna (voretigene neparvovec-rzyl)				

Clinical Information

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

* **THERAPY Start Date**: _____

1. Has patient had a positive response to the prescribed therapy? ☐Yes: _____ ☐No ☐Not applicable
2. Has patient previously been treated with Luxturna in the requested treatment eye(s)?
   ☐Yes, left eye ☐Yes, right eye ☐Yes, both eyes ☐No
   a. *If yes*, how many days have passed since treatment of first eye?
      ☐Left eye: _____ days ☐Right eye: _____ days
3. Which eye is this request for? ☐Left ☐Right ☐Both
   a. How many doses of Luxturna has patient received? ☐Left eye: ☐0 ☐≥ 1 ☐Right eye: ☐0 ☐≥ 1

Complete this section ONLY if the patient is initiating therapy OR if the patient is new to this health plan:

4. Is therapy prescribed by or in consultation with an ophthalmologist? ☐Yes ☐No
5. Is diagnosis confirmed by presence of biallelic *RPE65* gene mutations? ☐Yes ☐No
6. Does patient have sufficient viable retinal cells evidenced by either of the following? ☐Yes **Mark all that apply** ☐No
   ☐Retinal thickness on spectral domain optical coherence tomography (i.e., areas of retina with thickness measurements > 100 microns within the posterior pole)
   ☐Fundus photography (i.e., presence of neural retina)
7. Does patient have significant vision loss evidenced by either of the following? ☐Yes **Mark all that apply** ☐No
   ☐Visual acuity of 20/60 or worse in both eyes ☐Visual field less than 20 degrees in any meridian
8. Has patient received intraocular surgery within the prior 6 months? ☐Yes ☐No
9. Please document the following patient information:
   a. Baseline full-field stimulus testing (FST) for blue and red light score: _____ log10(cd/m^2)
   b. Vector genomes per eye: ☐Left eye _____ vg; ☐Right eye _____ vg

Complete this section ONLY for indications <u>other</u> than retinal dystrophy:

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: _____

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

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

Voretigene neparvovec-rzyl (Luxturna)
PDAC Drug Review Form

b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

Please continue to page 2.

Patient Name: _____ **DOB:** _____

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

*** 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.

☐ 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.372 Voretigene Neparvovec-rzyl (Luxturna)**]
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)