BlueCross BlueShield of Illinois

Anti-VEGF Intravitreal Injection Therapy Verification Form

Blue Cross and Blue Shield of Illinois reviews voluntary requests for pre-service recommended clinical review (predetermination) of anti-VEGF (vascular endothelial growth factor) intravitreal injections for certain conditions of the eye when services are proposed for our **commercial non-HMO** and **Federal Employee Program®** members.

Recommended clinical review determinations are made based on medical necessity criteria outlined in the following medical policies:*

- BCBSIL's Medical Policies – OTH903.026, OTH903.027, OTH903.041, OTH903.043, OTH903.044
- FEP® Medical Policies – 5.90.026, 5.90.029, 5.90.05, 5.90.052

**Note: This list of policies may change. Please check the websites for any other policies that may apply.*

The purpose of this therapy verification form is to help you prepare prior to submitting a voluntary request for recommended clinical review to BCBSIL.

Instructions

This form includes important reminders and a Provider Questionnaire. Think of it as a worksheet to help clarify your voluntary request for recommended clinical review.

1. **Review medical policy information.** Remember, before you begin, review the applicable BCBSIL or FEP medical policy for coverage criteria that may apply.
2. **Answer all questions in the appropriate Section(s) below.** This will help clarify Continuation Therapy and/or Initial Therapy details.
3. **Gather all necessary medical record documentation, as appropriate, to support your request.**
4. **Submit this completed form and supporting medical record documentation to BCBSIL, along with your voluntary request for recommended clinical review.** See below for electronic options to submit voluntary recommended clinical review requests and supporting documentation. **Electronic options are preferred to help expedite your request.** Alternatively, you can download and complete a paper recommended clinical review form and fax your information to BCBSIL.
   - Commercial non-HMO member requests at BCBSIL – **Use BlueApprovR℠** or the **Availity® Attachments tool** on the Availity Essentials portal.
   - FEP member requests – Use the **Availity® Attachments tool**.

Note: Failure to include necessary medical record documentation may result in delays or hinder the ability to confirm medical necessity of your request.

Provider Questionnaire

Section A – Continuation Therapy

1. Is the member currently receiving the requested medication through a previously authorized pharmacy or medical benefit? ☐ Yes ☐ No
2. What is the current dosing supported by an authoritative source?
3. Is the member benefiting from therapy as evidenced by disease stability or disease improvement? ☐ Yes ☐ No

Section B – Initial Therapy

1. Has the member tried and failed, or has a reason to avoid intravitreal injections(s) of bevacizumab (Avastin™) as an anti-VEGF therapy been determined? ☐ Yes ☐ No
2. Please include a brief explanation regarding your response above.

Review the applicable BCBSIL or FEP medical policy for coverage criteria that may apply.

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