HUSKY Health Program Encelto™ (revakinagene taroretcel-lwey)
Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.

Member Information			
Member ID #:		Member Name (Last, First):	
Address:		City, State, Zip:	
DOB:	Sex:	Primary Diagnosis Code:	
Date of Service:		HCPCS Code:	Dose:

Please fill out completely for all requests:		
1. Is the individual 21 years of age or older?	◯Yes	◯No
2. Is Encelto™ prescribed by, and will Encelto™ be administered by, a qualified ophthalmologist using a single surgical intravitreal procedure? ***If yes, please specify:*** Provider Name: _____ Phone Number: _____	◯Yes	◯No
3. Does the individual have a diagnosis of idiopathic Macular Telangiectasia Type 2 (MacTel)? ***Please attach medical record documentation.***	◯Yes	◯No
4. Does the individual have a photoreceptor Inner Segment/Outer Segment (IS/OS) break (loss) in Ellipsoid Zone (EZ) between 0.16 and 2.00 mm^2 measured by spectral domain-optical coherence tomography? ***Please attach signed provider attestation.***	◯Yes	◯No
5. Does the individual have a Best Corrected Visual Acuity (BCVA) of 54-letter score or better (20/80 or better) as measured by the Early Treatment Diabetic Retinopathy Study (ETDRS) chart? ***Please attach signed provider attestation.***	◯Yes	◯No
6. Does the individual have neovascular macular telangiectasia? ***Please attach signed provider attestation.***	◯Yes	◯No
7. Does the individual have an active or suspected ocular or periocular infection? ***Please attach signed provider attestation.***	◯Yes	◯No
8. Does the individual have a hypersensitivity to Endothelial Serum Free Media (Endo-SFM)? ***Please attach signed provider attestation.***	◯Yes	◯No
9. Has the individual received intravitreal anti-Vascular Endothelial Growth Factor (anti-VEGF) therapy in the affected eye(s)? ***Please attach signed provider attestation.***	◯Yes	◯No
10. Has the individual received intravitreal steroid therapy within the last three months? ***Please attach signed provider attestation.***	◯Yes	◯No
11. Is the individual taking antithrombotic medications (e.g., oral anticoagulants, aspirin, nonsteroidal anti-inflammatory drugs)?	◯Yes	◯No
a. If yes, will they be temporarily discontinued prior to surgical insertion of Encelto™? ***Please attach signed provider attestation.***	◯Yes	◯No
12. Will the treating provider follow all FDA-approved labeling for dosing, administration, and additional monitoring for Encelto™?	◯Yes	◯No

Billing Provider Information	
Medicaid Billing Number:	Billing Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	
Ordering Provider Information	
Medicaid Billing Number:	Ordering Provider Name:
Street Address:	City, State, Zip:
Contact Name:	Contact Telephone Number:
Contact Fax Number:	Provider Specialty:

Certification Statement: This is to certify that the requested medication is medically indicated and is reasonable and necessary for the treatment of this patient, and that a prescribing practitioner signed order is on file. This form, and any statement on my letterhead attached hereto, has been completed by me or by my employee, and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.

Provider Signature:	Date: