HUSKY Health Program LUXTURNA®
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:	Age:	Sex:	LUXTURNA® Dose:	Primary Diagnosis:	Date of Service:

Please fill out completely.		
1. Does the patient have confirmed biallelic RPE65 mutation-associated retinal dystrophy? *If yes, please attach documentation.*	☐ Yes	☐ No
2. Will LUXTURNA® be prescribed and administered by a retinal specialist?	☐ Yes	☐ No
3. Does the patient have viable retinal cells in the eye(s) intended to be treated, as determined by the treating physician?	☐ Yes	☐ No
4. Is the patient > 12 months of age, but < 65 years of age?	☐ Yes	☐ No
5. Has the patient previously received RPE65 gene therapy in the eye(s) intended to be treated?	☐ Yes	☐ No
6. Will the provider follow all FDA recommendations for dosage, preparation, administration, monitoring, and patient education?	☐ Yes	☐ No

Note: Review criteria are used as guidelines only. Determinations are based on a person-centered assessment of the individual and their unique clinical needs. Additional information submitted with this request will be considered as part of the medical necessity review process, in accordance with Conn. Gen. Stat. Sec. 17b-259b.

Billing Provider Information		
Medicaid Billing Number:		Billing Provider Name:
Street Address:		City, State Zip:
Phone #:	Fax #:	Contact Name:

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

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.

Physician Signature:	**Date:**