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:

Please fill out completely		
1. Does the patient have confirmed biallelic RPE65 mutation associated retinal dystrophy? *Please attach documentation*	☐ Yes	☐ No
2. Does the patient have viable retinal cells?	☐ Yes	☐ No
3. Will Luxturna™ be administered via subretinal injection to each eye on separate days within a close interval but no fewer than 6 days apart?	☐ Yes	☐ No
4. Will the dose administered be 1.5 X 10^{11} vector genomes per eye?	☐ Yes	☐ No
5. Will the injection be administered in an area away from the immediate vicinity of the fovea?	☐ Yes	☐ No
6. Will the patient receive systemic oral corticosteroids following FDA recommendations?	☐ Yes	☐ No
7. Will the patient be monitored for signs of infection, visual disturbances, retinal abnormalities, and increased intraocular pressure post injection?	☐ Yes	☐ No
8. Will the patient be instructed to avoid air travel, travel to high elevations, and scuba diving until the air bubble formed following administration of Luxturna™ has completely dissipated with confirmation by ophthalmic examination?	☐ 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:**