Vascular Endothelial Growth Factor (VEGF) Inhibitor Supplemental TAR Request Form

Patient Name: ____________________ PHC Member ID: ___________________ Provider Specialty: ________________

1. TAR Renewal with no change in drug, dose or units requested: Jump to Section 4

2. New Starts & Rx Changes: Product & Billing Information

A. Provider is aware of the potentially dramatic cost savings with the use of compounded Avastin and has weighed the benefits/risks of using compounded Avastin for treatment in place of Eylea or Lucentis:

This request is for Avastin Yes No Member has tried & failed Avastin

B. Drug requested:

Avastin 1.25 mg
Eylea 2.0 mg
Lucentis 0.3 mg
Lucentis 0.5 mg
Macugen 0.3 mg
Other:
____

C. Confirmed diagnosis & for use in:

Neovascular (wet) Age-related Macular Degeneration **(AMD)**
Diabetic Macular Edema **(DME)**
Macular Edema following Retinal Vein Occlusion **(RVO)**
Diabetic Retinopathy **(DR)**
Other: ____________________

D. For treatment of:

Right Eye (OD)
Left Eye (OS)
Both Eyes (OU) – concurrent treatment

E. Dosing frequency of:

Every 4 weeks (monthly)
Every 6 weeks
Every 8 weeks
Other:
____

F. Number of doses requested: _________ **per** eye

This request is part of a rotational drug treatment plan

Request for Eylea must clarify:

This is an initial request for first 3 monthly starting doses for AMD

This is an initial request for first 5 monthly starting doses for DME / DR

This is a request for monthly dosing for RVO or monthly (every 4 weeks) maintenance dosing for AMD, DME or DR.

This is a request for every other month (every 8 weeks) maintenance dosing for AMD, DME, or DR

3. Recommended Option Information

Baseline Visual Acuity Scores:

- OD SC or CC: ____________
- OS SC or CC: ____________

For DME (if available):

- HbA1C: _________ %

4. Renewal – Continuation of Therapy Rationale

Patient has had a stabilization or a decrease in rate of vision loss compared to baseline
Patient has had improvement in BCVA score compared to baseline

➢ NOTE: Clinic notes will be requested annually for ongoing treatment beyond 12 months' duration. If notes are submitted with the TAR renewal, TAR turn-around time is greatly reduced.

5. Provider Acknowledgement

To the best of my knowledge, the information provided in this form is (1) true, accurate and complete and (2) the requested services are medically indicated and necessary to the health of the patient.

Prescriber Signature: ____ Date: ____________________