Voretigeme neparvovec-rzyl (Luxturna)

Washington State Health Care Authority

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Without this information, we may deny the request in 30 days.**

A typed and completed *General Authorization for Information* form (13-835) must be attached to your request and must be the first page (no cover sheet). Fax to: 1-866-668-1214

1 General information

Date of request | Patient | Date of birth

ProviderOne client ID | Prescriber | Billing provider NPI number

Telephone number | Fax number

Drug/strength/dose/frequency

2 Patient information

1. Is patient's diagnosis biallelic RPE65 mutation associated-retinal dystrophy confirmed by genetic testing? ☐ Yes ☐ No
   If no, specify diagnosis:

2. Specify patient's eye(s) intended for treatment: ☐ Right ☐ Left ☐ Both
   For both eyes: Will the initial eye and second eye injections be administered at least 6 days apart? ☐ Yes ☐ No

3. Is patient's visual acuity worse than 20/60 in both eyes or visual field is less than 20 degrees in any meridian? ☐ Yes ☐ No

4. Does patient have documented viable retinal cells? ☐ Yes ☐ No
   If yes, verified by:
   - ☐ Area of the retina within the posterior pole of >100 um thickness shown on optical coherence tomography (OCT)
   - ☐ Three or more disc areas of retina without atrophy or pigmentary degeneration within the posterior pole
   - ☐ Remaining visual field within 30 degrees of fixation as measured by a III4e isopter or equivalent

5. Has patient previously received RPE65 gene therapy for the eye(s) intended for treatment? ☐ Yes ☐ No

6. Has patient had intraocular surgery within the last 6 months for the eye(s) intended for treatment? ☐ Yes ☐ No

7. Will the patient be started on a systemic corticosteroid equivalent to prednisone at 1mg/kg/day (Max of 40mg/day), starting 3 days before administration of Voretigene neparvovec-rzyl to each eye followed by a tapering dose for the next 10 days? ☐ Yes ☐ No

8. Is this prescribed and will be administered by an ophthalmologist or retinal surgeon who specializes in performing intraocular surgery? ☐ Yes ☐ No

All the following are required with this request:

- Genetic testing/documentation confirming diagnosis
- Results of optical coherence tomography (OCT) imaging and/or ophthalmoscopy
- Chart notes

3 Prescriber's signature

Prescriber's signature	Prescriber's specialty	Date