Oxervate (cenegermin-bkbj)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Satege 2 Persistent epithelial defect(PED) due to neurotrophic keratopathy ☐ Stage 3 Corneal ulcer due to neurotrophic keratopathy ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Is drug being used as part of a clinical trial? ☐ Yes ☐ No

Has patient used Oxervate(cenegermin) previously? ☐ Yes ☐ No ***Please provide dates of treatment.***

Does the patient's neurotrophric keratopathy affect both eyes? ☐ Yes ☐ No

Has the patient had the keratopathy for at least 2 weeks? ☐ Yes ☐ No

Has a Sensitivity test (such as by wisp test or Cochet-Bonnet aesthesiometer) demonstrated a decreased corneal sensitivity within the area of the PED or corneal ulcer? ☐ Yes ☐ No ***Please provide chart documentation.***

Did the Sensitivity test also demonstrate a decreased corneal sensitivity in at least one quadrant outside of the area of the defect? ☐ Yes ☐ No ***Please provide chart documentation.***

Has patient failed an adequate trial of at least one of the following: punctal occlusion, scleral or therapeutic contact lenses, autologous serum tears, amniotic membrane ring or transplantation, correction of concomitant lid malposition, epithelial debridement and/or corneal neurotization? ☐ Yes ☐ No ***Please provide chart documentation.***

Has the patient undergone tarsorraphy or conjunctival flap procedure? ☐ Yes ☐ No
Has the patient had a botulinum toxin injection to induce pharmacological blepharoptosis in the past 90days? ☐ Yes ☐ No

Does the patient have any active ocular infection or inflammation UNRELATED to neurotrophic keratopathy? ☐ Yes ☐ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

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Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management, LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811