



Oxervate (cenegermin-bkbj) Prior Authorization Request Form



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

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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page





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

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:**

<input type="checkbox"/> Stage 2 Persistent epithelial defect (PED) due to neurotrophic keratopathy <input type="checkbox"/> Stage 3 Corneal ulcer due to neurotrophic keratopathy <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
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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 neurotrophic keratopathy affect both eyes? Yes No

Is the prescriber a neuro-ophthalmologist or corneal subspecialist OR has there been a consult with a neuro-ophthalmologist or corneal subspecialist? Yes No *Please provide the consultation report confirming diagnosis.*

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 tarsorrhaphy or conjunctival flap procedure? Yes No

Has the patient had a botulinum toxin injection to induce pharmacological blepharoptosis in the past 90 days?
 Yes No

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





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

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:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

