HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
OXERVATE®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Oxervate® (cenergermin-bkbj)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
NEUROTROPHIC KERATITIS			
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider an ophthalmologist?	☐	☐	
3. Does the member have a diagnosis of stage 2 or 3 neurotrophic keratitis in one or both eyes?	☐	☐	**Please provide documentation**
4. Has corneal sensation been measured and shows reduction?	☐	☐	**Please provide documentation**
5. Has the member experienced persistent epithelial defects (PED) of at least 2 weeks or more that is refractory to treatment with one or more conventional treatments for neurotrophic Keratitis (artificial tears, gel, or ointment)?	☐	☐	**Please provide documentation**
6. Does the member have a best corrected distance visual acuity (BCDVA) score of ≤ 75 Early Treatment Diabetic Retinopathy Study (ETDRS) letters, (≥ + 0.2 LogMAR, ≤ 20/32 Snellen or ≤ 0.625 decimal fraction) in the affected eye?	☐	☐	**Please provide documentation**
7. Has the member received Oxervate in the past?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

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Policy: PHARM-CHIP-128
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024