



PRIOR AUTHORIZATION REQUEST

OXERVATE

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for ALL PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request for an INITIAL therapy or a CONTINUATION of therapy?

Initial (If checked, go to 7)

Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No

[If no, skip to question 7.]

**If you have any
questions, call:
1-888-258-8250**

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient completed a total of 8 weeks of lifetime treatment with the requested medication for affected eye(s)? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [Note: Authorization will only be granted to complete 8 weeks of total treatment.] [No further questions.]	Yes	No
7	What is the indication or diagnosis? <input type="checkbox"/> Neurotrophic keratitis (If checked, go to 8) <input type="checkbox"/> Other (If checked, no further questions)		
8	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
9	Does the provider attest that the total treatment duration for the patient will not exceed 8 weeks per affected eye? [If no, no further questions.]	Yes	No
10	Is the requested medication being prescribed by or in consultation with an ophthalmologist? [If no, no further questions.]	Yes	No
11	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [Dose: 6 drops daily per affected eye.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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