PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Oxervate - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Oxervate - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Oxervate (cenegermin)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: No approval extensions will be authorized.

[If yes, no further questions.]

2. Does the patient have a documented diagnosis of stage 2 or stage 3 neurotrophic keratitis in one or both eyes, as Y N _____

	evidenced by one of the following: A) Persistent epithelial defects, B) Corneal ulcer?		
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
3.	Is the patient 2 years of age or older?	Y N	
	[If no, no further questions.]		
4.	Has the patient had trial and inadequate response to at least one formulary over the counter (OTC) ocular artificial tear product?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
5.	Is the prescriber an ophthalmologist, or has the prescriber consulted with an ophthalmologist?	Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date