

Prior Authorization Request Form for
cenegermin-bkjb ophthalmic solution (**Oxervate**)



JOHNS HOPKINS
HEALTHCARE

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USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 Please complete patient and physician information (please print):

1 Patient Name: _____ Physician Name: _____
 Address: _____ Address: _____
 Sponsor ID #: _____ Phone #: _____
 Date of Birth: _____ Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Does the patient have a documented diagnosis of neurotrophic keratitis?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Is this medication being prescribed by a cornea specialist or ophthalmologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Is the patient 2 years of age or older?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Does the patient wear contact lenses?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Sign and date below
5. Will the patient remove contact lenses prior to administration and reinsert contact lenses no sooner than 15 minutes after the dose?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

 Prescriber Signature Date

[30 August 2019]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: