Prior Authorization Request Form for
oxymetazoline ophthalmic solution **(Upneeq)**

JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

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

USFHP Pharmacy Prior Authorization Form

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

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):

Patient Name: ____________________ Physician Name: ____________________

Address: ____________________ Address: ____________________

____________________ ____________________

Sponsor ID # ____________________ Phone #: ____________________

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question		
1. **Is the patient 13 years of age or older?**	☐ Yes Proceed to Question **2**	☐ No **STOP** **Coverage not approved**
2. **For which indication or diagnosis is the requested medication being prescribed?**	☐ Acquired blepharoptosis - Proceed to Question **3** ☐ Other - **STOP Coverage not approved**	
3. **Is the diagnosis of acquired blepharoptosis affirmed by a positive phenylephrine test indicating ptosis correction is achievable with Müller's muscle contraction?**	☐ Yes Proceed to Question **4**	☐ No **STOP** **Coverage not approved**
4. **Is the diagnosis of acquired blepharoptosis affirmed by marginal reflex distance 1 (MRD1) of less than 2 mm?**	☐ Yes Proceed to Question **5**	☐ No **STOP** **Coverage not approved**
5. **Have the patient and provider decided that the patient is not a good candidate for surgical intervention?**	☐ Yes **Sign and date below**	☐ 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

Prior Authorization Request Form for oxymetazoline ophthalmic solution **(Upneeq)**

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: