



Prior Authorization
<b>JOHNS HOPKINS HEALTHCARE (MEDICAID)</b> 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 Healthcare at <b>1-410-424-4607</b> . Please contact Johns Hopkins Healthcare at <b>1-888-819-1043</b> 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)
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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:	_____

<b>Diagnosis:</b> _____	<b>ICD Code:</b> _____
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Comments: _____
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<b>Please circle the appropriate answer for each question.</b>	
1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> 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 _____	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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.

<b>Prescriber (Or Authorized) Signature and Date</b>