



Oxervate

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ☐ Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ☐ Same as Referring Provider ☐ Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

Please indicate the place of service for the requested drug:

- | | | |
|--|---------------------------------|---|
| ☐ Ambulatory Surgical | ☐ Home | ☐ Off Campus Outpatient Hospital |
| ☐ On Campus Outpatient Hospital | ☐ Office | ☐ Pharmacy |

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Oxervate SGM 2869-A- 04/2025.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

Criteria Questions:

1. What is the diagnosis?

☐ Neurotrophic keratitis, *Continue to 2*

☐ Other, please specify. _____, *Continue to 2*

2. What is the severity of the neurotrophic keratitis?

☐ Stage 1, *Continue to 3*

☐ Stage 2, *Continue to 3*

☐ Stage 3, *Continue to 3*

☐ Other, *Continue to 3*

3. Is the requested drug prescribed by or in consultation with an ophthalmologist or optometrist?

☐ Yes, *Continue to 4*

☐ No, *Continue to 4*

4. Did the patient experience persistent epithelial defects (PED) or corneal ulceration of at least 2 weeks duration that was refractory to one or more conventional non-surgical treatments (e.g., preservative free artificial tears)?

☐ Yes, *Continue to 5*

☐ No, *Continue to 5*

5. Does the patient have evidence of decreased corneal sensitivity (e.g., cotton swab method, Cochet-Bonnet contact aesthesiometer, CRCERT-Belmonte non-contact aesthesiometer) within the area of the PED or corneal ulcer and outside of the area of the defect in at least one corneal quadrant?

☐ Yes, *Continue to 6*

☐ No, *Continue to 6*

6. Has the patient ever received Oxervate in the affected eye?

☐ Yes, *Continue to 7*

☐ No, *No Further Questions*

7. Has the patient received a previous 8-week course of Oxervate in the affected eye?

☐ Yes, *Continue to 8*

☐ No, *Continue to 8*

8. Is the patient currently receiving Oxervate in the affected eye?

☐ Yes, *Continue to 9*

☐ No, *Continue to 9*

9. How many weeks of Oxervate therapy has the patient received for the affected eye?

_____ week(s), *No further questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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