CAREFIRST COMMERCIAL - NON-RISK - SPC
Oxervate SGM

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at 866-249-6155. Please contact CVS Caremark at 866-814-5506 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Oxervate SGM.

Patient Information

Patient Name:
Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐
Patient ID:
Patient Group:
Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name
Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐
Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐
Physician Addr.:
City, St, Zip:

Drug Name (select from list of drugs shown)

Oxervate

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Neurotrophic keratitis (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) _____

2. What is the severity of the neurotrophic keratitis?
   - Stage 1 (If checked, no further questions) ☐
   - Stage 2 (If checked, go to 3) ☐
   - Stage 3 (If checked, go to 3) ☐
   - Other (If checked, no further questions) ☐

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

4. 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? **Y** ☐ **N** ☐

5. Has the patient ever received Oxervate in the affected eye? **Y** ☐ **N** ☐

6. Has the patient received a previous 8 week course of Oxervate in the affected eye? **Y** ☐ **N** ☐

7. Is the patient currently receiving Oxervate in the affected eye? **Y** ☐ **N** ☐

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

- 1 week (If checked, no further questions) ☐
- 2 weeks (If checked, no further questions) ☐
- 3 weeks (If checked, no further questions) ☐
- 4 weeks (If checked, no further questions) ☐
- 5 weeks (If checked, no further questions) ☐
- 6 weeks (If checked, no further questions) ☐
- 7 weeks (If checked, no further questions) ☐
- Greater than or equal to 8 weeks (If checked, no further questions) ☐

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