



OXERVATE
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)				Provider Information (required)			
Date:				Provider Name:			
Patient Name:				Specialty:		NPI:	
Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Office Phone:		Office Fax:	
Street Address:				Office Street Address:			
City:		State:	Zip:	City:		State:	Zip:
Patient ID:	<div style="border: 1px solid black; padding: 2px;"> <div style="float: left; width: 20px; text-align: center; font-weight: bold;">R</div> <div style="float: right; width: 100px; text-align: center;"> <div style="display: flex; justify-content: space-around;"> <div style="width: 15px; height: 15px; border: 1px solid black;"></div> <div style="width: 15px; height: 15px; border: 1px solid black;"></div> <div style="width: 15px; height: 15px; border: 1px solid black;"></div> <div style="width: 15px; height: 15px; border: 1px solid black;"></div> <div style="width: 15px; height: 15px; border: 1px solid black;"></div> <div style="width: 15px; height: 15px; border: 1px solid black;"></div> <div style="width: 15px; height: 15px; border: 1px solid black;"></div> <div style="width: 15px; height: 15px; border: 1px solid black;"></div> </div> </div> </div>			Physician Signature:			
PHYSICIAN COMPLETES							

Oxervate (cenegermin-bkbj)

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ☒ Brand ☐ Generic

1. What is the patient's diagnosis?

- ☐ Neurotrophic keratitis

- ☐ Other diagnosis (*please specify*): _____

2. Has the patient received Oxervate previously? *Please select answer below:*

- ☐ **NO** – this is **INITIATION** of Oxervate therapy, please answer the following question:

- a. Which eye is going to be treated? ☐ Left eye ☐ Right eye ☐ Both eyes

- ☐ **YES** – this is a PA renewal for **CONTINUATION** of Oxervate therapy, please answer the following questions:

- a. Which eye was previously treated? ☐ Left eye ☐ Right eye ☐ Both eyes

- b. Which eye is to be treated? ☐ Left eye ☐ Right eye ☐ Both eyes

3. Will the patient or the patient's caregiver be counseled on the proper administration technique of Oxervate? ☐Yes ☐No



**BlueCross
BlueShield**

Federal Employee Program.

Message:

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Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug prior authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA .
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same info contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727 Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the PA request cannot be processed. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u>

**faster...
easier...
better...**

Introducing ePA! Online Prior Authorizations in minutes through **Caremark.com/ePA**. Sign up today!

CVS/caremark 