OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: Oxervate™ (cenegermin-bkbj)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Authorization is limited to 8 weeks and maximum of 56 vials per eye per lifetime

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Prescribed by or in consultation with an ophthalmologist or optometrist
- ❑ Member is 2 years of age or older
- ❑ Provider must specify the affected eye(s) to be treated:

  Left eye: _____ Right eye: _____ Both eyes: _____
- ❑ Documentation must be submitted to confirm a diagnosis of **ONE** of the following stages of neurotrophic keratitis (in one or both eyes)
  - ❑ Stage 2: Recurrent or persistent epithelial defects without stromal involvement
  - ❑ Stage 3: Stromal melting leading to corneal ulcer
- ❑ Documentation must be submitted to confirm evidence of decreased corneal sensitivity in at least 1 corneal quadrant of ≤ 4 cm using the Cochet-Bonnet aesthesiometer
- ❑ Member has a BCDVA score of ≤ 75 ETDRS letters
- ❑ Member does **NOT** have severe blepharitis and/or severe meibomian gland disease
- ❑ Member is refractory to **ALL** of the following conventional non-surgical treatments of neurotrophic keratitis attempted within the last 180 days **(verified by chart notes or pharmacy paid claims)**:
  - ❑ Ophthalmic lubricants (e.g., Systane®, Blink® tears, Refresh®, generic artificial tears)
  - ❑ Therapeutic contact lenses
  - ❑ Ophthalmic corticosteroids (e.g., prednisolone acetate, fluoromethelone) or ophthalmic NSAIDs (e.g., ketorolac, diclofenac)

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

Medication being provided by Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 7/20/2019
REVISED/UPDATED: ~~08/13/2019, 11/15/2019; 3/4/2020; 5/9/22; 6/13/2022;~~ **6/17/2022**