Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Oxervate (cenegermin-bkbj) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 8 weeks per eye;
Continuation- N/A – therapy limited to 8 weeks/eye per lifetime

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Oxervate (cenegermin-bkbj)** for **Commercial, Exchange, FEHB (Federal), MD Medicaid,** and **VA Medicaid** plans. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

The KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____
Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy: **Not covered**, therapy limited to 8 weeks per eye per lifetime

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is the prescriber an Ophthalmologist?
   □ No □ Yes

2. Is the patient 2 years of age or older?
   □ No □ Yes

3. Does the patient have a documented diagnosis of moderate to severe neurotrophic keratitis?
   □ No □ Yes

4. Is there documented history of failure to ALL of the following non-surgical options?
   - OTC artificial tear products, gels, or lubricant ointments
   - Therapeutic Contact Lenses
   - Autologous Serum eye drops (unless contraindicated)

   □ No □ Yes

5. Does prescriber attest that patient is NOT a candidate for surgical therapies?
   □ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**